



PEACE LAND MEDICAL CENTER



MEDICAL EXAMINATION REPORT (CONFIDENTIAL)

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Surname	ABDUL REHMAN
Forenames	ACCAH DITTA
Address	65721792 - Toulouman
Home telephone number	97634627

Place of examination	my-	Date	27/6/21
If a dependant enter employee's name here: Surname:			
Birth date:	15/3/79	Nationality:	
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced	Forenames:	
Relationship to employee		Country of birth:	Religion:
<input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter		Number of children:	
Reason for examination	Pre-Employment <input type="checkbox"/> Periodic medical check-up <input type="checkbox"/>	Job: Driver.	
Pre-Overseas <input type="checkbox"/>		Area:	
Name and address of family doctor		List your last 3 jobs	
		(1)	
		(2)	
		(3)	

Are you a Registered Disabled Person? (UK only) ☐

Do you belong to any Medical Insurance Scheme? ☐

DO YOU HAVE OR HAVE YOU HAD:- (Tick "Yes" or "No" column or put a (?) if uncertain exclude minor ailments.)

	Y	N		Y	N		Y	N	
1. Sinus trouble			21. Cancer			HAVE YOU EVER BEEN:-			
2. Neck swelling/glands			22. Heart Disease				41. Rejected for employment or insurance for medical reasons		
3. Difficulty in vision			23. Rheumatic fever				42. Awarded benefits for industrial injury/illness		
4. Any ear discharge			24. Abnormal heartbeat				43. Treated for a mental condition, e.g. depression		
5. Asthma/bronchitis			25. High blood pressure				44. Treated for problem drinking or drug abuse		
6. Hayfever /other significant allergy			26. Stroke			45. Exposed to toxic substance or noise			
7. Any skin trouble			27. Serious chest pain			FOR WOMEN ONLY			
8. Tuberculosis			28. Any blood disease				Have you ever had:-		
9. Shortness of breath			29. Kidney disease				46. An abnormal smear		
10. Coughed/vomited blood			30. Blood in urine				47. Any gynaecological treatment		
11. Severe abdominal pain			31. Painful passage of urine				48. Are you pregnant?		
12. Stomach ulcer			32. Diabetes			49. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE			
13. Recurrent indigestion			33. Headaches/migraine						
14. Jaundice or hepatitis			34. Dizziness/fainting						
15. Gall Bladder disease			35. Epilepsy						
16. Marked change in bowel habits			36. Joints/spinal trouble						
17. Blood in stools (motions)			37. Surgical operation						
18. Marked change in weight			38. Serious accident/fracture						
19. Varicose veins			39. Tropical disease						
20. Lump in breast/arnpit			40. Fear of heights						

How much tobacco each day? No

Average daily alcohol consumption No

Have you ever taken elicited drugs? ()

FAMILY HISTORY: Diabetes () Tuberculosis () Epilepsy () Asthma () Eczema ()
Heart disease () High blood pressure () Stroke () Blood Disease () Cancer ()

PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT:-

I declared these statements to be true to the best of my knowledge and belief and I agree that the result of this medical examination in general terms may be revealed to the Company if required, and the details sent to my own doctor if this is considered necessary by the examining medical officer.

Date:

27/6/21

Signature of Applicant: ACCAH DITTA

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FOR COMPLETION BY EXAMINING DOCTOR OR NURSE
Further details of medical history and recreational activities

N = Normal A = Abnormal (please describe)

PHYSICAL EXAMINATION

N	A	
<input checked="" type="checkbox"/>		1. Eyes & Pupils
<input checked="" type="checkbox"/>		2. E.N.T.
<input checked="" type="checkbox"/>		3. Teeth & Mouth
<input checked="" type="checkbox"/>		4. Lungs & Chest
<input checked="" type="checkbox"/>		5. Cardiovascular System
<input checked="" type="checkbox"/>		6. Abdo. Viscera
<input checked="" type="checkbox"/>		7. Hernial Orifices
		8. Anus & Rectum
<input checked="" type="checkbox"/>		9. Genito-urinary
<input checked="" type="checkbox"/>		10. Extremities
<input checked="" type="checkbox"/>		11. Musculo-skeletal
<input checked="" type="checkbox"/>		12. Skin & Varicose Vns.
<input checked="" type="checkbox"/>		13. C.N.S.
		14. Breast

HEIGHT cm	WEIGHT kg	BMI	B.P. (MMHG)	PULSE	HEARING	VISION	Colour Vision	Blood Group
175	95	31	137 86	79 mins.	L N R N	DISTANT Uncorrected 5/6 Corrected 6/6 NEAR R L	ne	

N	A		LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A	
<input checked="" type="checkbox"/>		1. Urinalysis		<input checked="" type="checkbox"/>		7. Audiogram
<input checked="" type="checkbox"/>		2. Hb, Bloodcount, ESR				8. Lung Function
<input checked="" type="checkbox"/>		3. LFT, RFT, RBS				9. Chest X-Ray
		4. Drug Screen				10. ECG
	<input checked="" type="checkbox"/>	5. Lipids (40 years +)	high	<input checked="" type="checkbox"/>		11. CVS risk for 40 yrs. & above
<input checked="" type="checkbox"/>		6. Sickie Cell test				12. HIV, Hepatitis screening

OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)

Admission: Diet control, regular education & follow up.

ASSESSMENT:

☒ FIT ALL AREAS ☐ FIT WITH RESTRICTION ☐ TEMPORARY UNFIT ☐ UNFIT

Date: 28/6/2011 Name (Block Capitals): Dr. / Nurse

Signature:

Dr. ABULRAHMAN ABDULLATEIF
General Practitioner
MOH License No. 19486

REVIEW/CONSULTATION

Date: Name (Block Capitals): Dr. / Nurse

Signature: