



MEDICAL EXAMINATION REPORT (CONFIDENTIAL)

PLEASE COMPLETE YOUR PERSONAL  
DETAILS IN BLOCK CAPITALS

Surname: <b>HUSSAIN</b>		Forenames: <b>RAFQAT HUSSAIN</b>	
Address: <b>101602393 - Premises Logster</b>		Home telephone number: <b>94465097</b>	
Place of examination: <b>mt</b>	Date: <b>1/3/21</b>		
If a dependant enter employee's name here: Surname: <b>10/4/81</b>		Forenames: <b>Pakistan</b>	
Birth date: <b>10/4/81</b>	Nationality: <b>Pakistan</b>	Country of birth: <b>Pakistan</b>	Religion: <b>Muslim</b>
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced	Relationship to employee <input type="checkbox"/> Wife <input checked="" type="checkbox"/> Son <input checked="" type="checkbox"/> Daughter	Number of children: <b>5</b>
Reason for examination Pre-Employment <input type="checkbox"/> Periodic medical check-up <input type="checkbox"/> Pre-Overseas <input type="checkbox"/>		Job: <b>Operator</b> Area:	
Name and address of family doctor		List your last 3 jobs	
		(1)	
		(2)	
		(3)	
Are you a Registered Disabled Person? (UK only) <input type="checkbox"/>		Do you belong to any Medical Insurance Scheme? <input type="checkbox"/>	
DO YOU HAVE OR HAVE YOU HAD:- (Tick "Yes" or "No" column or put a (?) if uncertain exclude minor ailments.)			
	Y	N	
1. Sinus trouble		<input checked="" type="checkbox"/>	21. Cancer
2. Neck swelling/glands		<input checked="" type="checkbox"/>	22. Heart Disease
3. Difficulty in vision		<input checked="" type="checkbox"/>	23. Rheumatic fever
4. Any ear discharge		<input checked="" type="checkbox"/>	24. Abnormal heartbeat
5. Asthma/bronchitis		<input checked="" type="checkbox"/>	25. High blood pressure
6. Hayfever /other significant allergy		<input checked="" type="checkbox"/>	26. Stroke
7. Any skin trouble		<input checked="" type="checkbox"/>	27. Serious chest pain
8. Tuberculosis		<input checked="" type="checkbox"/>	28. Any blood disease
9. Shortness of breath		<input checked="" type="checkbox"/>	29. Kidney disease
10. Coughed/vomited blood		<input checked="" type="checkbox"/>	30. Blood in urine
11. Severe abdominal pain		<input checked="" type="checkbox"/>	31. Painful passage of urine
12. Stomach ulcer		<input checked="" type="checkbox"/>	32. Diabetes
13. Recurrent indigestion		<input checked="" type="checkbox"/>	33. Headaches/migraine
14. Jaundice or hepatitis		<input checked="" type="checkbox"/>	34. Dizziness/fainting
15. Gall Bladder disease		<input checked="" type="checkbox"/>	35. Epilepsy
16. Marked change in bowel habits		<input checked="" type="checkbox"/>	36. Joints/spinal trouble
17. Blood in stools (motions)		<input checked="" type="checkbox"/>	37. Surgical operation
18. Marked change in weight		<input checked="" type="checkbox"/>	38. Serious accident/fracture
19. Varicose veins		<input checked="" type="checkbox"/>	39. Tropical disease
20. Lump in breast/armpit		<input checked="" type="checkbox"/>	40. Fear of heights
How much tobacco each day? <b>No</b>		Average daily alcohol consumption <b>No</b>	
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: <b>1/3/21</b>		Signature of Applicant: <b>[Signature]</b>	



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						
✓		1. Eyes & Pupils					
✓		2. E.N.T.					
✓		3. Teeth & Mouth					
✓		4. Lungs & Chest					
✓		5. Cardiovascular System					
✓		6. Abdo. Viscera					
✓		7. Hernial Orifices					
✓		8. Anus & Rectum					
✓		9. Genito-urinary					
✓		10. Extremities					
✓		11. Musculo-skeletal					
✓		12. Skin & Varicose Vns.					
✓		13. C.N.S.					
		14. Breast					
HEIGHT cm	WEIGHT kg	BMI	B.P (MMHG)	PULSE	HEARING L R	VISION DISTANT R L NEAR R L Uncorrected Corrected	Colour Vision Blood Group
169	63	22	117 74	61/min.	N	6/6 6/6 6/6 6/6	N
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS				N	A
✓		1. Urinalysis			✓		7. Audiogram
✓		2. Hb, Bloodcount, ESR			✓		8. Lung Function
✓		3. LFT, RFT, RBS					9. Chest X-Ray
		4. Drug Screen			✓		10. ECG
✓		5. Lipids (40 years +)			28%		11. CVS risk for 40 yrs. & above
✓		6. Sickie Cell test					12. HIV, Hepatitis screening

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

ASSESSMENT:

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

Date: 11/3/2021 Name (Block Capitals): Dr. / Nurse

Signature:

REVIEW/CONSULTATION

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

Signature:

