



PEACE LAND MEDICAL CENTER



MEDICAL EXAMINATION REPORT (CONFIDENTIAL)

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Place of examination **SAYYAH** Date **5/6/2021**If a dependant enter employee's name here:
Surname:Birth date: **11/12/73** Nationality: **PAKISTANI** Country of birth: **PAKISTAN** Religion: **MUSLIM**
 Male Female Married Single Separated /Divorced Relationship to employee
 Wife Son Daughter Number of children: **5**Reason for examination Pre-Employment Periodic medical check-up Job: **H. DRIVER.**
Pre-Overseas 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 | | <input checked="" type="checkbox"/> | 21. Cancer | | <input checked="" type="checkbox"/> | HAVE YOU EVER BEEN:- | | |
| 2. Neck swelling/glands | | <input checked="" type="checkbox"/> | 22. Heart Disease | | <input checked="" type="checkbox"/> | 41. Rejected for employment or insurance for medical reasons | | |
| 3. Difficulty in vision | | <input checked="" type="checkbox"/> | 23. Rheumatic fever | | <input checked="" type="checkbox"/> | 42. Awarded benefits for industrial injury/illness | | |
| 4. Any ear discharge | | <input checked="" type="checkbox"/> | 24. Abnormal heartbeat | | <input checked="" type="checkbox"/> | 43. Treated for a mental condition, e.g. depression | | |
| 5. Asthma/bronchitis | | <input checked="" type="checkbox"/> | 25. High blood pressure | | <input checked="" type="checkbox"/> | 44. Treated for problem drinking or drug abuse | | |
| 6. Hayfever /other significant allergy | | <input checked="" type="checkbox"/> | 26. Stroke | | <input checked="" type="checkbox"/> | 45. Exposed to toxic substance or noise | | |
| 7. Any skin trouble | | <input checked="" type="checkbox"/> | 27. Serious chest pain | | <input checked="" type="checkbox"/> | FOR WOMEN ONLY | | |
| 8. Tuberculosis | | <input checked="" type="checkbox"/> | 28. Any blood disease | | <input checked="" type="checkbox"/> | Have you ever had:- | | |
| 9. Shortness of breath | | <input checked="" type="checkbox"/> | 29. Kidney disease | | <input checked="" type="checkbox"/> | 46. An abnormal smear | | |
| 10. Coughed/vomited blood | | <input checked="" type="checkbox"/> | 30. Blood in urine | | <input checked="" type="checkbox"/> | 47. Any gynaecological treatment | | |
| 11. Severe abdominal pain | | <input checked="" type="checkbox"/> | 31. Painful passage of urine | | <input checked="" type="checkbox"/> | 48. Are you pregnant? | | |
| 12. Stomach ulcer | | <input checked="" type="checkbox"/> | 32. Diabetes | | <input checked="" type="checkbox"/> | 49. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE | | |
| 13. Recurrent indigestion | | <input checked="" type="checkbox"/> | 33. Headaches/migraine | | <input checked="" type="checkbox"/> | | | |
| 14. Jaundice or hepatitis | | <input checked="" type="checkbox"/> | 34. Dizziness/fainting | | <input checked="" type="checkbox"/> | | | |
| 15. Gall Bladder disease | | <input checked="" type="checkbox"/> | 35. Epilepsy | | <input checked="" type="checkbox"/> | | | |
| 16. Marked change in bowel habits | | <input checked="" type="checkbox"/> | 36. Joints/spinal trouble | | <input checked="" type="checkbox"/> | | | |
| 17. Blood in stools (motions) | | <input checked="" type="checkbox"/> | 37. Surgical operation | | <input checked="" type="checkbox"/> | | | |
| 18. Marked change in weight | | <input checked="" type="checkbox"/> | 38. Serious accident/fracture | | <input checked="" type="checkbox"/> | | | |
| 19. Varicose veins | | <input checked="" type="checkbox"/> | 39. Tropical disease | | <input checked="" type="checkbox"/> | | | |
| 20. Lump in breast/armpit | | <input checked="" type="checkbox"/> | 40. Fear of heights | | <input checked="" type="checkbox"/> | | | |

How much tobacco each day? **8/10 DAILY** Average daily alcohol consumption **N/A**

Have you ever taken elicited drugs? ()

| | | | | | |
|-----------------|-------------------|-------------------------|--------------|-------------------|------------|
| FAMILY HISTORY: | Diabetes () | Tuberculosis () | Epilepsy () | Asthma () | Eczema () |
| NA | 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: **5/6/2021**

Signature of Applicant:

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