



## PEACE LAND MEDICAL CENTER



## MEDICAL EXAMINATION REPORT (CONFIDENTIAL)

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Place of examination <i>out</i>		Date <i>27/6/21</i>	Surname <i>HOWLADEH</i>		
			Forenames <i>MUHAMMAD RANA</i>		
			Address <i>115373 Ugg - Tmonay</i>		
			Home telephone number <i>79488714</i>		
If a dependant enter employee's name here: Surname: <i>123456</i>		Forenames: <i></i>			
Birth date: <i>5/2/97</i>		Nationality: <i>Bangladesh</i>	Country of birth: <i>Bangladesh</i>	Religion: <i>Muslim</i>	
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced	<input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	Relationship to employee <i>Rigger</i>	
Reason for examination		Pre-Employment <input type="checkbox"/>	Periodic medical check-up <input type="checkbox"/>	Job: <i>Rigger</i>	
		Pre-Overseas <input type="checkbox"/>		Area: <i></i>	
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.)					
1. Sinus trouble 2. Neck swelling/glands 3. Difficulty in vision 4. Any ear discharge 5. Asthma/bronchitis 6. Hayfever /other significant allergy 7. Any skin trouble 8. Tuberculosis 9. Shortness of breath 10. Coughed/vomited blood 11. Severe abdominal pain 12. Stomach ulcer 13. Recurrent indigestion 14. Jaundice or hepatitis 15. Gall Bladder disease 16. Marked change in bowel habits 17. Blood in stools (motions) 18. Marked change in weight 19. Varicose veins 20. Lump in breast/armpit		Y <input type="checkbox"/> N <input type="checkbox"/> 21. Cancer 22. Heart Disease 23. Rheumatic fever 24. Abnormal heartbeat 25. High blood pressure 26. Stroke 27. Serious chest pain 28. Any blood disease 29. Kidney disease 30. Blood in urine 31. Painful passage of urine 32. Diabetes 33. Headaches/migraine 34. Dizziness/fainting 35. Epilepsy 36. Joints/spinal trouble 37. Surgical operation 38. Serious accident/fracture 39. Tropical disease 40. Fear of heights		Y <input type="checkbox"/> N <input type="checkbox"/> HAVE YOU EVER BEEN:- 41. Rejected for employment or insurance for medical reasons 42. Awarded benefits for industrial injury/illness 43. Treated for a mental condition, e.g. depression 44. Treated for problem drinking or drug abuse 45. Exposed to toxic substance or noise FOR WOMEN ONLY Have you ever had:- 46. An abnormal smear 47. Any gynaecological treatment 48. Are you pregnant? 49. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE	
How much tobacco each day? <i>No</i>		Average daily alcohol consumption <i>No</i>			
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: <i>27/6/21</i>		Signature of Applicant: <i>RANA</i>			



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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										
/		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 /mins.	HEARING L R	VISION			Colour Vision	Blood Group
171		74	25.3	133 86	72	N	DISTANT R L	NEAR R L			
						Uncorrected Corrected	6/6 6/6				
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 +)						11. CVS risk for 40 yrs. & above			
/		6. Sickle Cell test						12. HIV, Hepatitis screening			
<b>OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)</b>											
<b>ASSESSMENT:</b>											
<input checked="" type="checkbox"/> FIT ALL AREAS		<input type="checkbox"/> FIT WITH RESTRICTION		<input type="checkbox"/> TEMPORARY UNFIT		<input type="checkbox"/> UNFIT					
Date: 28/6/2021		Name (Block Capitals): Dr. / Nurse		 PEACE LAND MEDICAL CENTER		Signature:				 Dr. ABDULLAHMAAN ABDULLAHEE General Practitioner MOPH License No. 1948	
<b>REVIEW/CONSULTATION</b>											
Date:		Name (Block Capitals): Dr. / Nurse						Signature:			