



MEDICAL EXAMINATION REPORT (CONFIDENTIAL)

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Surname	HOWLADER
Forenames	MOHAMMAD RANA
Address	115373499 - Tnebonan
Home telephone number	79488714

Place of examination	mit	Date	27/6/21
If a dependant enter employee's name here:			
Surname:		Forenames:	
Birth date:	5/2/97	Nationality:	Bangladeshi
Country of birth:		Bangladesh	
Religion:		Muslim	
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced	Relationship to employee	
		<input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	
Reason for examination		Number of children:	
Pre-Employment <input type="checkbox"/> Periodic medical check-up <input type="checkbox"/>			
Pre-Overseas <input type="checkbox"/>		Job: <u>Regger</u>	
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		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/arm/pit			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: RAHA



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
					L R	DISTANT R L	NEAR R L				
171	74	25.3	133 86	72/min.	L R	Uncorrected Corrected	6/6 6/6			N	

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		<input checked="" type="checkbox"/>	8. Lung Function
<input checked="" type="checkbox"/>		3. LFT, RFT, RBS			9. Chest X-Ray
<input checked="" type="checkbox"/>		4. Drug Screen			10. ECG
<input checked="" type="checkbox"/>		5. Lipids (40 years +)			11. CVS risk for 40 yrs. & above
<input checked="" type="checkbox"/>		6. Sickie Cell test			12. HIV, Hepatitis screening

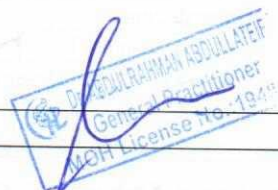
OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)

ASSESSMENT:

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

Date: 28/6/2024 Name (Block Capitals): Dr. / Nurse

Signature:



REVIEW/CONSULTATION

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

Signature: