



## PEACE LAND MEDICAL CENTER



## MEDICAL EXAMINATION REPORT (CONFIDENTIAL)

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Surname		Singh	
Forenames		nakhan	
Address		75949014 - Tonk Oman	
Home telephone number		95264676	
Forenames:		Brid	
Country of birth:		Religion: Hindu	
Relationship to employee		Number of children: 3	
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		<input checked="" type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	

Place of examination *ml* Date *12/7/21*

If a dependant enter employee's name here:

Surname:

Birth date: *03/6/73*Nationality: *indian*

Married

Single

Separated /Divorced

Wife

Son

Daughter

Reason for examination

Pre-Employment

Periodic medical check-up

Job: *driver*

Pre-Overseas

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? 

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

How much tobacco each day? *100*

Average daily alcohol consumption

*16*

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: *12/7/21*

Signature of Applicant:

*SM*



## PEACE LAND MEDICAL CENTER

 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 64/mins.	HEARING L R	VISION DISTANT Uncorrected Corrected	NEAR R L R L	Colour Vision	Blood Group
169	85	29.8	130/78						

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 +)	7.9%	11. CVS risk for 40 yrs. & above
/		6. Sickle Cell test		12. HIV, Hepatitis screening

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

Adm: Diet control, regular exercise & follow-up

## ASSESSMENT:

FIT ALL AREAS  FIT WITH RESTRICTION  TEMPORARY UNFIT  UNFIT

Date: 18/7/2018 Name (Block Capitals): Dr. / Nurse

Signature:



## REVIEW/CONSULTATION

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

Signature: