

6364

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS



INITIAL EXAMINATION REPORT

Surname <u>SINGH</u>	
Forenames <u>BALWINDER</u>	
Address <u>TRUKOMAN</u>	
Place of examination <u>RS PAC CLINIC BAHJA</u>	Date <u>13/07/19</u>
DOB: <u>30/05/1973</u> , CIVIL- <u>85409033</u> , STAFF- <u>6364</u>	
Home Telephone number <u>93503347</u>	

If a dependant or fancee entr employees name jere :-

Surname :

Forenames:

Nationality <u>INDIAN</u>		Country of birth <u>INDIA</u>		Religion <u>SIKHISM</u>	
<input checked="" type="checkbox"/> Male	<input checked="" type="checkbox"/> Single	<input checked="" type="checkbox"/> Widow(er)	Relationship to employee		
<input checked="" type="checkbox"/> Female	<input checked="" type="checkbox"/> Married	<input checked="" type="checkbox"/> Divorced Separated	<input checked="" type="checkbox"/> Wife	<input type="checkbox"/> Son	<input type="checkbox"/> Daughter
			<input type="checkbox"/> Fiancee	Number of Children <u>2</u>	
Reason for examination <input checked="" type="checkbox"/> Pre-employment		Job :- <u>DRIVER (HEAVY)</u>			
<input type="checkbox"/> Pre-overseas		Area:- <u>BAHJA</u>			

Name and address of family doctor	List your last 3 jobs
	(1)
	(2)
	(3)

Are you Registered Disabled Person? (UK ☐

☐

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

How much tobacco each day ? Non-smoker

Average daily alcohol consupction NO

Family history	Diabetes <input type="checkbox"/>	Tuberculosis <input checked="" type="checkbox"/>	Epilepsy <input type="checkbox"/>	Asthama <input checked="" type="checkbox"/>	Eczerna <input checked="" type="checkbox"/>
	Heart disease <input checked="" type="checkbox"/>	High blood pressure <input checked="" type="checkbox"/>	Stroke <input checked="" type="checkbox"/>	Cancer <input checked="" type="checkbox"/>	Blood disease <input checked="" type="checkbox"/>

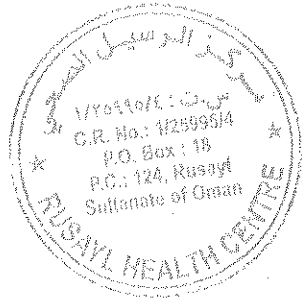
PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT :-

I declare these statements to be true to the best of my knowledge and belief and I agree that the result of this medical 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 13-07-19

Signature of applicant

FOR COMPLETION BY EXAMINING DOCTOR OR SISTER
FURTHER DETAILS OF MEDICAL HISTORY AND RECREATIONAL ACTIVITIES

N - Normal A - Abnormal Please Describe			PHYSICAL EXAMINATION
N	A		<div style="display: flex; justify-content: space-between;"> <div> <p>BMI - 31.1 kg/m²</p> <p>HR - 79 bpm</p> </div> <div style="text-align: center;">  </div> </div>
✓		1. Eyes & Pupils	
✓		2. E.N.T.	
✓		3. Teeth & Mouth	
✓		4. Lungs & Chest	
✓		5. Cardiovascular System	
✓		6. Abdo. Viscera	
✓		7. Hermlal Orifices	
✓		8. Anus & Rectum	
✓		9. Genito - urinary	
✓		10. Extremities	
✓		11. Muscula-skeletal	
✓		12. Skin & Varicose Vns.	
✓		13. C.N.S.	
✓		14. Breasts	
		15.	

HEIGHT cm	WEIGHT kg	B.P.	HEARING L	HEARING R	VISION: Uncorrected	VISION: Corrected	DISTANT R L	NEAR R L	COLOUR VISION	BLOOD GROUP
166	85.7	127/90	L	R			R L	R L		

N	A	LABORATORY AND SPECIAL INVESTIGATIONS	N	A
		1. Urinalysis		
		2. Hb Bloodcount ESR		
		3. Sarum Profile		
		4. Stool		
		5. E.C.G.		
		6. Audlogram		
		7. Lung Function		
		8. Chest X-Ray		
		9. Drug Screen		
		10. CR Screen		

OTHER FINDINGS (physique, scars, disabilities, mental stability etc.)


BMI - 31.1 kg/m²

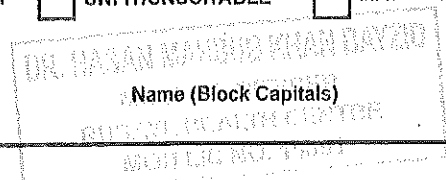
Sickle cell - Negative

- Advice
- Regular exercise
 - Weight reduction
 - Avoid high fat diet
 - Repeat LFT after 12 months.

ASSESSMENT

☒ FIT ALL AREAS
 ☐ FIT HOME SERVICES ONLY
 ☐ UNFIT/UNSUITABLE
 ☐ MAY BE REASSESSED

Date: 04-07-19
 Signature: 


Doctor / Sister

REVIEW/CONSULTATION

Date	Signature	Name (Block Capitals)	Doctor / Sister
------	-----------	-----------------------	-----------------