



PEACE LAND MEDICAL CENTER MUKHAIZNA



MEDICAL EXAMINATION REPORT (CONFIDENTIAL)

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Surname		Forenames		Address		Home telephone number	
		TONY HILARY PINTO		74090093		97240538	
Place of examination : MUKHAIZNA		Date : 5-9-22					
If a dependant enter employee's name here: Surname:		Forenames:					
Birth date: 31-5-69		Nationality: INDIAN		Country of birth: INDIA		Religion: CHRISTIAN	
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		<input checked="" 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		Number of children: 2	
Reason for examination Pre-Employment <input type="checkbox"/> Periodic medical check-up <input checked="" type="checkbox"/> Pre-Overseas <input type="checkbox"/>		Job: DRIVER		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	
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/armpit				40. Fear of heights			
How much tobacco each day? NO		Average daily alcohol consumption NO					
Have you ever taken elicited drugs? (X)							
FAMILY HISTORY: Diabetes (X) Tuberculosis (X) Epilepsy (X) Asthma (X) Eczema (X) Heart disease (X) High blood pressure (X) Stroke (X) Blood Disease (X) Cancer (X)							
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: 5-9-22		Signature of Applicant: Tony Pinto					





PEACE LAND MEDICAL CENTER MUKHAIZNA



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
<input checked="" type="checkbox"/>		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.
<input checked="" type="checkbox"/>		14. Breast

HEIGHT cm	WEIGHT kg	BMI	B.P.	PULSE / mins.	HEARING L R	VISION DISTANT R L NEAR R L Uncorrected Corrected	Colour Vision	Blood Group
165 cm	94 kg	34.5	120 70	73	L <input checked="" type="checkbox"/> R <input checked="" type="checkbox"/>	Uncorrected 6/6 Corrected 6/6	<input checked="" type="checkbox"/>	

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	<input checked="" type="checkbox"/>		9. Chest X-Ray
<input checked="" type="checkbox"/>		4. Drug Screen	<input checked="" type="checkbox"/>		10. ECG
<input checked="" type="checkbox"/>		5. Lipids (40 years +)	<input checked="" type="checkbox"/>		11. CVS risk for 40 yrs. & above
<input checked="" type="checkbox"/>		6. Sickle Cell test	<input checked="" type="checkbox"/>		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: Name (Block Capitals): Dr. / Nurse

Signature: Dr. MOHAMMOD ULLAH
General Practitioner
MOH License No. : 7790

REVIEW/CONSULTATION

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