



TONI



15732

PEACE LAND MEDICAL CENTER MUKHAIZNA

MEDICAL EXAMINATION REPORT (CONFIDENTIAL)

TONY HILARY
PINTOPLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Place of examination: MUKHAIZNA		Date: 5-9-22	Surname		
If a dependant enter employee's name here:		Forenames: TONY HILARY PINTO			Address: 74090093
Surname:		Forenames:			Home telephone number: 97240538
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	<input type="checkbox"/> Wife <input checked="" 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"/>	Job: DRIVER	
Pre-Overseas <input type="checkbox"/>		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.)					
1. Sinus trouble		Y <input type="checkbox"/>	N <input type="checkbox"/>	HAVE YOU EVER BEEN:-	
2. Neck swelling/glands		Y <input type="checkbox"/>	N <input type="checkbox"/>	41. Rejected for employment or insurance for medical reasons <input type="checkbox"/>	
3. Difficulty in vision		Y <input type="checkbox"/>	N <input type="checkbox"/>	42. Awarded benefits for industrial injury/illness <input type="checkbox"/>	
4. Any ear discharge		Y <input type="checkbox"/>	N <input type="checkbox"/>	43. Treated for a mental condition, e.g. depression <input type="checkbox"/>	
5. Asthma/bronchitis		Y <input type="checkbox"/>	N <input type="checkbox"/>	44. Treated for problem drinking or drug abuse <input type="checkbox"/>	
6. Hayfever /other significant allergy		Y <input type="checkbox"/>	N <input type="checkbox"/>	45. Exposed to toxic substance or noise <input type="checkbox"/>	
7. Any skin trouble		Y <input type="checkbox"/>	N <input type="checkbox"/>	FOR WOMEN ONLY	
8. Tuberculosis		Y <input type="checkbox"/>	N <input type="checkbox"/>	Have you ever had:-	
9. Shortness of breath		Y <input type="checkbox"/>	N <input type="checkbox"/>	46. An abnormal smear <input type="checkbox"/>	
10. Coughed/vomited blood		Y <input type="checkbox"/>	N <input type="checkbox"/>	47. Any gynaecological treatment <input type="checkbox"/>	
11. Severe abdominal pain		Y <input type="checkbox"/>	N <input type="checkbox"/>	48. Are you pregnant? <input type="checkbox"/>	
12. Stomach ulcer		Y <input type="checkbox"/>	N <input type="checkbox"/>	49. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE <input type="checkbox"/>	
13. Recurrent indigestion		Y <input type="checkbox"/>	N <input type="checkbox"/>		
14. Jaundice or hepatitis		Y <input type="checkbox"/>	N <input type="checkbox"/>		
15. Gall Bladder disease		Y <input type="checkbox"/>	N <input type="checkbox"/>		
16. Marked change in bowel habits		Y <input type="checkbox"/>	N <input type="checkbox"/>		
17. Blood in stools (motions)		Y <input type="checkbox"/>	N <input type="checkbox"/>		
18. Marked change in weight		Y <input type="checkbox"/>	N <input type="checkbox"/>		
19. Varicose veins		Y <input type="checkbox"/>	N <input type="checkbox"/>		
20. Lump in breast/armpit		Y <input type="checkbox"/>	N <input type="checkbox"/>		
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			

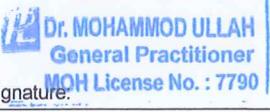




PEACE LAND MEDICAL CENTER MUKHAIZNA



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												
/	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.	PULSE / mins.	HEARING L R	VISION DISTANT Uncorrected Corrected	NEAR R L R L	Colour Vision	Blood Group				
165cm	94kg	34.5	120/70	73	N N	6/6/6/6	+	N					
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					
OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)													
ASSESSMENT:													
<input checked="" type="checkbox"/> FIT ALL AREAS		<input type="checkbox"/> FIT WITH RESTRICTION		<input type="checkbox"/> TEMPORARY UNFIT		<input type="checkbox"/> UNFIT							
Date:	Name (Block Capitals): Dr. / Nurse			 Signature: <i>[Signature]</i>									
REVIEW/CONSULTATION													
Date:	Name (Block Capitals): Dr. / Nurse			Signature:									

