

# 6438



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## PEACE LAND MEDICAL CENTER

## MEDICAL EXAMINATION REPORT (CONFIDENTIAL)

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Surname	AJITHKUMAR
Forenames	MADUSOODANA PAWICKER
Address	77139609 - Trivikram
Home telephone number	96178921

Place of examination: <i>muscat</i>	Date: <i>31/8/22</i>		
If a dependant enter employee's name here:			
Surname: <i>Inahen</i>			
Birth date: <i>4/5/1970</i>	Nationality: <i>Indian</i>		
<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: <i>2</i>
Reason for examination	Pre-Employment	<input checked="" type="checkbox"/> Periodic medical check-up <input type="checkbox"/> <input type="checkbox"/> Pre-Overseas	Job: <i>Rigger</i>
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.)		HAVE YOU EVER BEEN:-	
Y	N	Y	N
1. Sinus trouble		21. Cancer	
2. Neck swelling/glands		22. Heart Disease	
3. Difficulty in vision		23. Rheumatic fever	
4. Any ear discharge		24. Abnormal heartbeat	
5. Asthma/bronchitis		25. High blood pressure	
6. Hayfever /other significant allergy		26. Stroke	
7. Any skin trouble		27. Serious chest pain	
8. Tuberculosis		28. Any blood disease	
9. Shortness of breath		29. Kidney disease	
10. Coughed/vomited blood		30. Blood in urine	
11. Severe abdominal pain		31. Painful passage of urine	
12. Stomach ulcer		32. Diabetes	<input checked="" type="checkbox"/>
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	
FOR WOMEN ONLY			
Have you ever had:-			
41. Rejected for employment or insurance for medical reasons		42. Awarded benefits for industrial injury/illness	<input type="checkbox"/>
43. Treated for a mental condition, e.g. depression		44. Treated for problem drinking or drug abuse	<input type="checkbox"/>
45. Exposed to toxic substance or noise		46. An abnormal smear	
47. Any gynaecological treatment		48. Are you pregnant?	
49. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE			

How much tobacco each day? <i>No</i>	Average daily alcohol consumption <i>No</i>
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: <i>31/8/22</i>	Signature of Applicant: <i>AJith</i>
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*Known Dm. on Rx, T. Ravikumar 10 mg.*



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**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 R L				NEAR R L	Colour Vision	Blood Group	
167		73	26.2	122 / 86	67	N	Uncorrected Corrected				6/6 6/6	+	✓	
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 +)					9.41.		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.) <i>None of DM</i>														
1. NSM & RFP (↓wt, Exercise & diet)														
2. Regular FN every 3m by his own physician														
ASSESSMENT:														
<input checked="" type="checkbox"/> FIT ALL AREAS		<input type="checkbox"/> FIT WITH RESTRICTION		<input type="checkbox"/> TEMPORARY UNFIT		<input type="checkbox"/> UNFIT								
Date: 19/22		Name (Block Capitals): Dr. / Nurse		 Dr. Shima Seyedabdlah Jafar Cardiologist Specialist MOH LIC. No. 21982		Signature:								
REVIEW/CONSULTATION														
Date:		Name (Block Capitals): Dr. / Nurse							Signature:					