



N = Normal A = Abnormal (please describe)				PHYSICAL EXAMINATION							
N	A										
<input checked="" type="checkbox"/>		1. Eyes & Pupils		Normal & Reactive							
<input checked="" type="checkbox"/>		2. E.N.T.		DNS CRT							
<input checked="" type="checkbox"/>		3. Teeth & Mouth									
<input checked="" type="checkbox"/>		4. Lungs & Chest		Normal							
<input checked="" type="checkbox"/>		5. Cardiovascular System		S1, S2, no murmur							
<input checked="" type="checkbox"/>		6. Abdo. Viscera		Soft, no tenderness							
<input checked="" type="checkbox"/>		7. Hernial Orifices		Normal							
<input checked="" type="checkbox"/>		8. Anus & Rectum		Normal							
<input checked="" type="checkbox"/>		9. Genito-urinary		Normal							
<input checked="" type="checkbox"/>		10. Extremities		Normal							
<input checked="" type="checkbox"/>		11. Musculo-skeletal		Normal							
<input checked="" type="checkbox"/>		12. Skin & Varicose Vns.		Normal							
<input checked="" type="checkbox"/>		13. C.N.S.		Normal							
HEIGHT cm	WEIGHT kg	BMI	B.P.	PULSE	HEARING	VISION				Colour Vision	Blood Group
162	70.5	26.9	124/86	62/min.	L <input checked="" type="checkbox"/> R <input checked="" type="checkbox"/>	DISTANT	NEAR				
						Uncorrected	R	L	R	L	
						Corrected	6/6	6/6	6/6	6/6	4/6
											4/6
											O+ve
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						8. Lung Function			
<input checked="" type="checkbox"/>		3. LFT, RFT, RBS						9. Chest X-Ray			
		4. Drug Screen				<input checked="" type="checkbox"/>		10. ECG			
<input checked="" type="checkbox"/>		5. Lipids (40 years +)						11. CVS risk for 40 yrs. & above			
<input checked="" type="checkbox"/>		6. Sickle Cell test						12. HIV, Hepatitis screening			
<p>OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)</p> <p>Normal Exam / Dup on oral medication &amp; lips.</p>											
<p>ASSESSMENT:</p> <p>FIT ALL AREAS <input checked="" type="checkbox"/> FIT WITH RESTRICTION <input type="checkbox"/> TEMPORARILY UNFIT <input type="checkbox"/> UNFIT <input type="checkbox"/></p> <p><b>FIT</b></p>											
<p>Date: 26/10/2020 Name (Block Capitals): Dr. / Nurse Signature:</p>											
<p>REVIEW/CONSULTATION</p>											
<p>Date: 26/10/2020 Name (Block Capitals): Dr. / Nurse Signature:</p>											



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