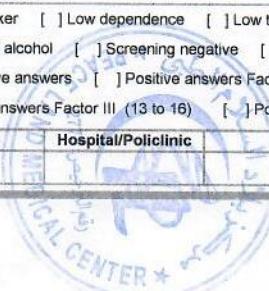


MEDICAL EVALUATION REPORT FOR OQ CONTRACTORS - SUMMARY

T.O.



Civil ID / Passport #		Company ID #		MANJIT SINGH # 0044500 # 39 Y(M) BAS-Rev Bill: 00533		IFICATION	
V9045-35				 79857 <Blank> 08/08/23 09:48		Position HDD	
Nationality	Age	Sex					Location
Indian	15/3/84 M						
EXAMINATION TYPE							
Examination	<input type="checkbox"/> Pre-employment		<input type="checkbox"/> Periodic		<input type="checkbox"/> Exit		
VITAL SIGNS & BODY MEASURES							
Blood Pressure Category:	<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Prehypertension <input type="checkbox"/> Hypertension Stage 1 <input type="checkbox"/> Hypertension Stage 2 <input type="checkbox"/> Hypertension Crises						
BMI Category:	<input type="checkbox"/> Underweight <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Overweight <input type="checkbox"/> Obese <input type="checkbox"/> Morbid Obesity						
Remarks:							
VISUAL TEST							
Visual Acuity Test	RT 6/6	LT 6/6	Visual Field Test		<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal		
Colour Vision Test	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Not Required		<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Required		
Pre-existing condition:							
Remarks:							
RESPIRATORY SYSTEM							
Spirometry Test	<input type="checkbox"/> Normal		<input type="checkbox"/> Abnormal		<input type="checkbox"/> Not Required		
Pre-existing condition:	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Required						
Remarks:							
ENT SYSTEM							
Audiometry Test	<input checked="" type="checkbox"/> Normal		<input type="checkbox"/> Abnormal		<input type="checkbox"/> Not Required		
Pre-existing condition:	<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Required (Whisper, Weber & Rinne Tests)						
Remarks:							
CARDIOVASCULAR SYSTEM							
ECG Test	<input checked="" type="checkbox"/> Normal		<input type="checkbox"/> Abnormal		<input type="checkbox"/> Not Required		
Pre-existing condition:							
Remarks:							
NEUROLOGICAL SYSTEM							
Physical Assessment	<input checked="" type="checkbox"/> Normal		<input type="checkbox"/> Abnormal		<input type="checkbox"/> Not Required		
Pre-existing condition:							
Remarks:							
MUSCULOSKELETAL SYSTEM							
Physical Assess.	<input checked="" type="checkbox"/> Normal		<input type="checkbox"/> Abnormal		<input type="checkbox"/> Not Required		
Pre-existing condition:							
Remarks:							
LABORATORY INVESTIGATIONS							
Lab Tests:	<input checked="" type="checkbox"/> Normal		<input type="checkbox"/> Abnormal		If abnormal, please specify below:		
Pre-existing condition:							
Remarks:							
Glucose Level Category	<input type="checkbox"/> Normal 80 – 100 mg/dl <input type="checkbox"/> Pre diabetic 100 – 125 mg/dl <input type="checkbox"/> Diabetic > 126 mg/dl						
Cholesterol Risk Category	<input checked="" type="checkbox"/> Low Risk LDL is less 130 mg/dl <input type="checkbox"/> Moderate Risk LDL 130-159 mg/dl <input type="checkbox"/> High Risk LDL >160 mg/dl						
Routine Urine Analysis	<input checked="" type="checkbox"/> Normal		<input type="checkbox"/> Abnormal		<input type="checkbox"/> Not Required		
Stool Analysis <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Required							
QUESTIONNAIRES							
Medical & Surgical History Questionnaire	Remarks						
Respiratory Protection Questionnaire	Remarks						
Hearing Conservation Questionnaire	Remarks						
Screening Questionnaire	Remarks						
Fagerstrom Test - Smoking	<input type="checkbox"/> Non-smoker <input type="checkbox"/> Low dependence <input type="checkbox"/> Low to Mod dependence <input type="checkbox"/> Moderate dependence <input type="checkbox"/> High dependence						
CAGE Questionnaire Alcohol Use	<input type="checkbox"/> No use of alcohol <input type="checkbox"/> Screening negative <input type="checkbox"/> Clinically significant						
SRQ-20 Self-reported Questionnaire	<input type="checkbox"/> No positive answers <input type="checkbox"/> Positive answers Factor I (1 to 6) <input type="checkbox"/> Positive answers Factor II (7 to 12) <input type="checkbox"/> Positive answers Factor III (13 to 16) <input type="checkbox"/> Positive answers Factor IV (17 to 20)						
Clinic Doctor Name	License #	Hospital/Polyclinic	Doctor Signature & Clinic Stamp				Issue Date
				 09-8-23			

FITNESS TO WORK CERTIFICATE - OQ CONTRACTORS



EMPLOYEE IDENTIFICATION			
Civil ID / Passport #	Company ID #	Position	
		HDD	
Nationality	Age	Sex	
EXAMINATION TYPE			
<input type="checkbox"/> Pre-employment Examination (PRE)	<input type="checkbox"/> Periodic Medical Examination (PME)	<input type="checkbox"/> Post-absence Examination	
<input type="checkbox"/> Change of Position Examination	<input type="checkbox"/> Exit Examination	<input type="checkbox"/> Critical Activities Examination	
<input type="checkbox"/> Emergency Response Team	<input type="checkbox"/> Travelling Examination	<input type="checkbox"/> Medical Surveillance	
Medical Suitability for Work			
Medical Suitability for Work	<input checked="" type="checkbox"/> Fit to work	FIT	
	<input type="checkbox"/> Fit with following restrictions		
	<input type="checkbox"/> Pending Fitness		
	<input type="checkbox"/> Not fit to work		
Restrictions			
<input type="checkbox"/> Working at height	<input type="checkbox"/> Pulling, pushing or carrying weight		
<input type="checkbox"/> Working in confined space	<input type="checkbox"/> Ascend/descend ladders and stairs		
<input type="checkbox"/> Working with electricity	<input type="checkbox"/> Walking or standing for long distance/period		
<input type="checkbox"/> Working near rotating machinery	<input type="checkbox"/> Repetitive movements		
<input type="checkbox"/> Working in noise area	<input type="checkbox"/> Mobile machinery operation		
<input type="checkbox"/> Working in extreme heat	<input type="checkbox"/> Heavy lifting operation		
<input type="checkbox"/> Handling chemical products	<input type="checkbox"/> Driving vehicle		
<input type="checkbox"/> Use of respirator	<input type="checkbox"/> Emergency response duty		
Other, specify			
New Position	New Function	New Department	
NA	NA	NA	
Examination Date	Exams Performed		
8/8/23	<i>Lipid Boreldium</i> <i>Advised - diet</i> <i>- exercise + diet control</i> <i>- follow-up in 3 months & Review</i>		
Medical Review Date	Employee Signature		
9-8-23			
Doctor Name	Medical License	Hospital	Medical Doctor Signature

