



PEACE LAND MEDICAL CENTER MUKHAIZNA

MEDICAL EXAMINATION REPORT (CONFIDENTIAL)

lant 16687 Reg.Dt 28/08/2022
no BALU NARAYANASWAMY

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Place of examination : <u>MUKHAIZNA</u> Date : <u>28-8-22</u>		Surname	
If a dependant enter employee's name here: Surname:		Forenames <u>BALU NARAYANASWAMY</u>	
Birth date: <u>8-3-61</u> Nationality: <u>INDIAN</u>		Address <u>10797.5401</u>	
		Home telephone number <u>94645127</u> (<u>Emp #1616</u>)	
Forenames:		Relationship to employee	
Country of birth: <u>INDIA</u> Religion: <u>HINDU</u>		Number of children: <u>3</u>	
<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 type="checkbox"/> Son <input type="checkbox"/> Daughter	
Reason for examination		Job: <u>CARPENTER</u>	
Pre-Employment <input type="checkbox"/> Periodic medical check-up <input checked="" type="checkbox"/> 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.)			
Y N		Y N	
1. Sinus trouble	I	21. Cancer	I
2. Neck swelling/glands	I	22. Heart Disease	I
3. Difficulty in vision	I	23. Rheumatic fever	I
4. Any ear discharge	I	24. Abnormal heartbeat	I
5. Asthma/bronchitis	I	25. High blood pressure	I
6. Hayfever /other significant allergy	I	26. Stroke	I
7. Any skin trouble	I	27. Serious chest pain	I
8. Tuberculosis	I	28. Any blood disease	I
9. Shortness of breath	I	29. Kidney disease	I
10. Coughed/vomited blood	I	30. Blood in urine	I
11. Severe abdominal pain	I	31. Painful passage of urine	I
12. Stomach ulcer	I	32. Diabetes	I
13. Recurrent indigestion	I	33. Headaches/migraine	I
14. Jaundice or hepatitis	I	34. Dizziness/fainting	I
15. Gall Bladder disease	I	35. Epilepsy	I
16. Marked change in bowel habits	I	36. Joints/spinal trouble	I
17. Blood in stools (motions)	I	37. Surgical operation	I
18. Marked change in weight	I	38. Serious accident/fracture	I
19. Varicose veins	I	39. Tropical disease	I
20. Lump in breast/armpit	I	40. Fear of heights	I
How much tobacco each day? <u>NO</u>		Average daily alcohol consumption <u>NO</u>	
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: <u>28-8-22</u>		Signature of Applicant: <u>N. Balu</u>	



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.
170	83	28.72	110/75
PULSE	HEARING	VISION	Colour Vision
60/min.	L ✓ R ✓	DISTANT R L Uncorrected 6/6 6/6 Corrected	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: <u>06/09/2012</u> DR. NISANTH KALLINKEEL Specialist - Internal Medicine nmc speciality hospital, Al-Hail			
Signature:			
REVIEW/CONSULTATION			
- Reviewed the patient.			
- He is asymptomatic, vitals stable.			
- Medication started for lipids and uric acid			
Date: <u>06/09/2012</u> Name (Block Capitals): Dr. / Nurse			
Signature:			

No absolute contraindication for continuing the work

06/09/2012
DR. NISANTH KALLINKEEL
Specialist - Internal Medicine
MOH Lic. No: 16847
nmc speciality hospital, Al-Hail