



# PEACE LAND MEDICAL CENTER



## MEDICAL EXAMINATION REPORT (CONFIDENTIAL)

PLEASE COMPLETE YOUR PERSONAL  
DETAILS IN BLOCK CAPITALS

Surname	KHALFAN AL FAHARI
Forenames	KHALFAN SALEM
Address	161754550 Tarek Omar
Home telephone number	96448156

Place of examination	ant	Date	30/8/21
If a dependant enter employee's name here:		Forenames:	
Surname:	Birth date:	Nationality:	Country of birth:
13/11/87	Oman	Oman	Muslim
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced	Relationship to employee	
Reason for examination		<input type="checkbox"/> Pre-Employment <input type="checkbox"/> Periodic medical check-up	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)		Do you belong to any Medical Insurance Scheme?	
<input type="checkbox"/>		<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	
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	
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	
How much tobacco each day? No		Average daily alcohol consumption No	
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: 30/8/21		Signature of Applicant: [Signature]	