



MEDICAL EXAMINATION REPORT (CONFIDENTIAL)

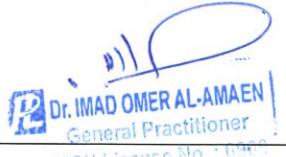
PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

		Surname A																																																																																					
		Forenames AMEER SAID																																																																																					
		Address 86919344 - PREMIER LOGISTICS																																																																																					
		Home telephone number 92647499																																																																																					
Place of examination MCT		Date 8/3/21																																																																																					
If a dependant enter employee's name here:																																																																																							
Surname:		Forenames:																																																																																					
Birth date: 1/1/67		Nationality: PAKISTANI																																																																																					
Relationship to employee		Number of children: 3																																																																																					
<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 checked="" type="checkbox"/> Son <input checked="" type="checkbox"/> Daughter																																																																																							
Reason for examination Pre-Employment		Periodic medical check-up																																																																																					
Pre-Overseas		Job: H.D.D																																																																																					
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.)																																																																																							
<table border="1"> <tr> <th>Y</th> <th>N</th> </tr> <tr> <td colspan="2">1. Sinus trouble</td> </tr> <tr> <td colspan="2">2. Neck swelling/glands</td> </tr> <tr> <td colspan="2">3. Difficulty in vision</td> </tr> <tr> <td colspan="2">4. Any ear discharge</td> </tr> <tr> <td colspan="2">5. Asthma/bronchitis</td> </tr> <tr> <td colspan="2">6. Hayfever /other significant allergy</td> </tr> <tr> <td colspan="2">7. Any skin trouble</td> </tr> <tr> <td colspan="2">8. Tuberculosis</td> </tr> <tr> <td colspan="2">9. Shortness of breath</td> </tr> <tr> <td colspan="2">10. Coughed/vomited blood</td> </tr> <tr> <td colspan="2">11. Severe abdominal pain</td> </tr> <tr> <td colspan="2">12. Stomach ulcer</td> </tr> <tr> <td colspan="2">13. Recurrent indigestion</td> </tr> <tr> <td colspan="2">14. Jaundice or hepatitis</td> </tr> <tr> <td colspan="2">15. Gall Bladder disease</td> </tr> <tr> <td colspan="2">16. Marked change in bowel habits</td> </tr> <tr> <td colspan="2">17. Blood in stools (motions)</td> </tr> <tr> <td colspan="2">18. Marked change in weight</td> </tr> <tr> <td colspan="2">19. Varicose veins</td> </tr> <tr> <td colspan="2">20. Lump in breast/armpit</td> </tr> </table>		Y	N	1. Sinus trouble		2. Neck swelling/glands		3. Difficulty in vision		4. Any ear discharge		5. Asthma/bronchitis		6. Hayfever /other significant allergy		7. Any skin trouble		8. Tuberculosis		9. Shortness of breath		10. Coughed/vomited blood		11. Severe abdominal pain		12. Stomach ulcer		13. Recurrent indigestion		14. Jaundice or hepatitis		15. Gall Bladder disease		16. Marked change in bowel habits		17. Blood in stools (motions)		18. Marked change in weight		19. Varicose veins		20. Lump in breast/armpit		<table border="1"> <tr> <th>Y</th> <th>N</th> </tr> <tr> <td colspan="2">21. Cancer</td> </tr> <tr> <td colspan="2">22. Heart Disease</td> </tr> <tr> <td colspan="2">23. Rheumatic fever</td> </tr> <tr> <td colspan="2">24. Abnormal heartbeat</td> </tr> <tr> <td colspan="2">25. High blood pressure <i>on Rel</i></td> </tr> <tr> <td colspan="2">26. Stroke</td> </tr> <tr> <td colspan="2">27. Serious chest pain</td> </tr> <tr> <td colspan="2">28. Any blood disease</td> </tr> <tr> <td colspan="2">29. Kidney disease</td> </tr> <tr> <td colspan="2">30. Blood in urine</td> </tr> <tr> <td colspan="2">31. Painful passage of urine</td> </tr> <tr> <td colspan="2">32. Diabetes</td> </tr> <tr> <td colspan="2">33. Headaches/migraine</td> </tr> <tr> <td colspan="2">34. Dizziness/fainting</td> </tr> <tr> <td colspan="2">35. Epilepsy</td> </tr> <tr> <td colspan="2">36. Joints/spinal trouble</td> </tr> <tr> <td colspan="2">37. Surgical operation</td> </tr> <tr> <td colspan="2">38. Serious accident/fracture</td> </tr> <tr> <td colspan="2">39. Tropical disease</td> </tr> <tr> <td colspan="2">40. Fear of heights</td> </tr> </table>		Y	N	21. Cancer		22. Heart Disease		23. Rheumatic fever		24. Abnormal heartbeat		25. High blood pressure <i>on Rel</i>		26. Stroke		27. Serious chest pain		28. Any blood disease		29. Kidney disease		30. Blood in urine		31. Painful passage of urine		32. Diabetes		33. Headaches/migraine		34. Dizziness/fainting		35. Epilepsy		36. Joints/spinal trouble		37. Surgical operation		38. Serious accident/fracture		39. Tropical disease		40. Fear of heights	
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HAVE YOU EVER BEEN:-																																																																																							
41. Rejected for employment or insurance for medical reasons <input checked="" type="checkbox"/>																																																																																							
42. Awarded benefits for industrial injury/illness <input checked="" type="checkbox"/>																																																																																							
43. Treated for a mental condition, e.g. depression <input checked="" type="checkbox"/>																																																																																							
44. Treated for problem drinking or drug abuse <input checked="" type="checkbox"/>																																																																																							
45. Exposed to toxic substance or noise <input checked="" type="checkbox"/>																																																																																							
FOR WOMEN ONLY																																																																																							
46. An abnormal smear <input type="checkbox"/>																																																																																							
47. Any gynaecological treatment <input type="checkbox"/>																																																																																							
48. Are you pregnant? <input type="checkbox"/>																																																																																							
49. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE <input type="checkbox"/>																																																																																							
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: 8/3/21		Signature of Applicant: <i>[Signature]</i>																																																																																					



PEACE LAND MEDICAL CENTER

 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															
<input checked="" type="checkbox"/>		1. Eyes & Pupils														
<input checked="" type="checkbox"/>		2. E.N.T.														
<input checked="" type="checkbox"/>		3. Teeth & Mouth														
<input checked="" type="checkbox"/>		4. Lungs & Chest														
<input checked="" type="checkbox"/>		5. Cardiovascular System														
<input checked="" type="checkbox"/>		6. Abdo. Viscera														
<input checked="" type="checkbox"/>		7. Hernial Orifices														
<input checked="" type="checkbox"/>		8. Anus & Rectum														
<input checked="" type="checkbox"/>		9. Genito-urinary														
<input checked="" type="checkbox"/>		10. Extremities														
<input checked="" type="checkbox"/>		11. Musculo-skeletal														
<input checked="" type="checkbox"/>		12. Skin & Varicose Vns.														
<input checked="" type="checkbox"/>		13. C.N.S.														
		14. Breast														
HEIGHT cm <i>175</i>		WEIGHT kg <i>106</i>	BMI <i>34.6</i>	B.P. (MMHG) <i>155/96</i>	PULSE <i>86</i> /mins.	HEARING L <i>N</i> R	VISION				Colour Vision <i>N</i>	Blood Group				
							DISTANT R L	NEAR R L								
						Uncorrected <i>6/9 6/9</i>	Corrected									
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									<input checked="" type="checkbox"/>		8. Lung Function			
<input checked="" type="checkbox"/>		3. LFT, RFT, RBS									<input checked="" type="checkbox"/>		9. Chest X-Ray			
		4. Drug Screen									<input checked="" type="checkbox"/>		10. ECG			
<input checked="" type="checkbox"/>		5. Lipids (40 years +)									<i>13.2%</i>		11. CVS risk for 40 yrs. & above			
<input checked="" type="checkbox"/>		6. Sickle Cell test											12. HIV, Hepatitis screening			
OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)																
<i>Obesity II for diet control & regular exercise.</i> <i>Hypertension on medications.</i>																
ASSESSMENT:																
<input checked="" type="checkbox"/> FIT ALL AREAS		<input type="checkbox"/> FIT WITH RESTRICTION		<input type="checkbox"/> TEMPORARY UNFIT		<input type="checkbox"/> UNFIT										
Date: <i>9/3/2021</i>		Name (Block Capitals): Dr. / Nurse						Signature: 								
REVIEW/CONSULTATION																
Date:		Name (Block Capitals): Dr. / Nurse						Signature:								

