



## PEACE LAND MEDICAL CENTER



## MEDICAL EXAMINATION REPORT (CONFIDENTIAL)

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Place of examination *MET* Date *21/6/21*

If a dependant enter employee's name here:

Surname:

Birth date: *20/8/65*Nationality: *Indian* Male  Female Married  Single  Separated /Divorced

Surname

Forenames

Address *64582768 - Tonet Oman Equum*

Home telephone number

*Riental 95627100*

Forenames:

Country of birth: *Indian*Religion: *Hindu* Wife  Son  Daughter

Number of children:

Reason for examination

Pre-Employment

 Periodic medical check-up Job: *Operator*

Pre-Overseas

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? 

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	<input checked="" type="checkbox"/>	<input type="checkbox"/>	21. Cancer	<input checked="" type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER BEEN:-
2. Neck swelling/glands	<input checked="" type="checkbox"/>	<input type="checkbox"/>	22. Heart Disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>	41. Rejected for employment or insurance for medical reasons
3. Difficulty in vision	<input checked="" type="checkbox"/>	<input type="checkbox"/>	23. Rheumatic fever	<input checked="" type="checkbox"/>	<input type="checkbox"/>	42. Awarded benefits for industrial injury/illness
4. Any ear discharge	<input checked="" type="checkbox"/>	<input type="checkbox"/>	24. Abnormal heartbeat	<input checked="" type="checkbox"/>	<input type="checkbox"/>	43. Treated for a mental condition, e.g. depression
5. Asthma/bronchitis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	25. High blood pressure	<input checked="" type="checkbox"/>	<input type="checkbox"/>	44. Treated for problem drinking or drug abuse
6. Hayfever /other significant allergy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	26. Stroke	<input checked="" type="checkbox"/>	<input type="checkbox"/>	45. Exposed to toxic substance or noise
7. Any skin trouble	<input checked="" type="checkbox"/>	<input type="checkbox"/>	27. Serious chest pain	<input checked="" type="checkbox"/>	<input type="checkbox"/>	FOR WOMEN ONLY
8. Tuberculosis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	28. Any blood disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Have you ever had:-
9. Shortness of breath	<input checked="" type="checkbox"/>	<input type="checkbox"/>	29. Kidney disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>	46. An abnormal smear
10. Coughed/vomited blood	<input checked="" type="checkbox"/>	<input type="checkbox"/>	30. Blood in urine	<input checked="" type="checkbox"/>	<input type="checkbox"/>	47. Any gynaecological treatment
11. Severe abdominal pain	<input checked="" type="checkbox"/>	<input type="checkbox"/>	31. Painful passage of urine	<input checked="" type="checkbox"/>	<input type="checkbox"/>	48. Are you pregnant?
12. Stomach ulcer	<input checked="" type="checkbox"/>	<input type="checkbox"/>	32. Diabetes	<input checked="" type="checkbox"/>	<input type="checkbox"/>	49. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE
13. Recurrent indigestion	<input checked="" type="checkbox"/>	<input type="checkbox"/>	33. Headaches/migraine	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
14. Jaundice or hepatitis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	34. Dizziness/fainting	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
15. Gall Bladder disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>	35. Epilepsy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
16. Marked change in bowel habits	<input checked="" type="checkbox"/>	<input type="checkbox"/>	36. Joints/spinal trouble	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
17. Blood in stools (motions)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	37. Surgical operation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
18. Marked change in weight	<input checked="" type="checkbox"/>	<input type="checkbox"/>	38. Serious accident/fracture	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
19. Varicose veins	<input checked="" type="checkbox"/>	<input type="checkbox"/>	39. Tropical disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
20. Lump in breast/armpit	<input checked="" type="checkbox"/>	<input type="checkbox"/>	40. Fear of heights	<input checked="" type="checkbox"/>	<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: *21/6/21*Signature of Applicant: *R. V. A.*