



## PEACE LAND MEDICAL CENTER

### MEDICAL EXAMINATION REPORT (CONFIDENTIAL)

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

#6712

Place of examination **MCT** Date **31/11/21**

Surname <b>AVATAR</b>	
Forenames <b>YUDHVEER SINGH</b>	
Address <b>104 352262 - PREMIER LOGISTIC</b>	
Home telephone number <b>94863424</b>	

If a dependant enter employee's name here: Surname: <b>INDIAN</b>		Forenames: <b>INDIAN</b>	
Birth date: <b>10/5/85</b>	Nationality: <b>INDIAN</b>	Country of birth: <b>INDIA</b>	Religion: <b>SINGH</b>
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced	<input checked="" type="checkbox"/> Wife <input checked="" type="checkbox"/> Son <input type="checkbox"/> Daughter	Relationship to employee Number of children: <b>2</b>
Reason for examination Pre-Employment	<input checked="" type="checkbox"/> Periodic medical check-up <input type="checkbox"/>	Job: <b>CRANE OPERATOR</b>	Area:
Pre-Overseas	<input type="checkbox"/>		

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"/>
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DO YOU HAVE OR HAVE YOU HAD:- (Tick "Yes" or "No" column or put a (?) if uncertain exclude minor ailments.)		HAVE YOU EVER BEEN:-	
Y	N	Y	N
1. Sinus trouble	<input checked="" type="checkbox"/>	21. Cancer	<input checked="" type="checkbox"/>
2. Neck swelling/glands	<input checked="" type="checkbox"/>	22. Heart Disease	<input checked="" type="checkbox"/>
3. Difficulty in vision	<input checked="" type="checkbox"/>	23. Rheumatic fever	<input checked="" type="checkbox"/>
4. Any ear discharge	<input checked="" type="checkbox"/>	24. Abnormal heartbeat	<input checked="" type="checkbox"/>
5. Asthma/bronchitis	<input checked="" type="checkbox"/>	25. High blood pressure	<input checked="" type="checkbox"/>
6. Hayfever /other significant allergy	<input checked="" type="checkbox"/>	26. Stroke	<input checked="" type="checkbox"/>
7. Any skin trouble	<input checked="" type="checkbox"/>	27. Serious chest pain	<input checked="" type="checkbox"/>
8. Tuberculosis	<input checked="" type="checkbox"/>	28. Any blood disease	<input checked="" type="checkbox"/>
9. Shortness of breath	<input checked="" type="checkbox"/>	29. Kidney disease	<input checked="" type="checkbox"/>
10. Coughed/vomited blood	<input checked="" type="checkbox"/>	30. Blood in urine	<input checked="" type="checkbox"/>
11. Severe abdominal pain	<input checked="" type="checkbox"/>	31. Painful passage of urine	<input checked="" type="checkbox"/>
12. Stomach ulcer	<input checked="" type="checkbox"/>	32. Diabetes	<input checked="" type="checkbox"/>
13. Recurrent indigestion	<input checked="" type="checkbox"/>	33. Headaches/migraine	<input checked="" type="checkbox"/>
14. Jaundice or hepatitis	<input checked="" type="checkbox"/>	34. Dizziness/fainting	<input checked="" type="checkbox"/>
15. Gall Bladder disease	<input checked="" type="checkbox"/>	35. Epilepsy	<input checked="" type="checkbox"/>
16. Marked change in bowel habits	<input checked="" type="checkbox"/>	36. Joints/spinal trouble	<input checked="" type="checkbox"/>
17. Blood in stools (motions)	<input checked="" type="checkbox"/>	37. Surgical operation	<input checked="" type="checkbox"/>
18. Marked change in weight	<input checked="" type="checkbox"/>	38. Serious accident/fracture	<input checked="" type="checkbox"/>
19. Varicose veins	<input checked="" type="checkbox"/>	39. Tropical disease	<input checked="" type="checkbox"/>
20. Lump in breast/armpit	<input checked="" type="checkbox"/>	40. Fear of heights	<input checked="" type="checkbox"/>

How much tobacco each day? <b>NO</b>	Average daily alcohol consumption <b>NO</b>
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Have you ever taken elicited drugs? <b>( )</b>
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FAMILY HISTORY: Diabetes <b>( )</b> Tuberculosis <b>( )</b> Epilepsy <b>( )</b> Asthma <b>( )</b> Eczema <b>( )</b> Heart disease <b>( )</b> High blood pressure <b>( )</b> Stroke <b>( )</b> Blood Disease <b>( )</b> Cancer <b>( )</b>
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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: <b>31/11/21</b>	Signature of Applicant: <b>AVATAR</b>



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FOR COMPLETION BY EXAMINING DOCTOR OR NURSE  
Further details of medical history and recreational activities

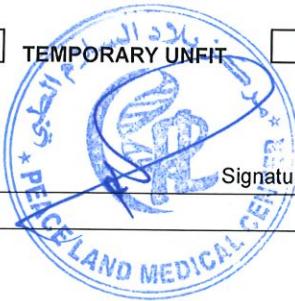
N = Normal A = Abnormal (please describe)		PHYSICAL EXAMINATION										
N	A											
	1. Eyes & Pupils											
	2. E.N.T.											
	3. Teeth & Mouth											
	4. Lungs & Chest											
	5. Cardiovascular System											
	6. Abdo. Viscera											
	7. Hernial Orifices											
	8. Anus & 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. (MMHG)	PULSE 80 /mins.	HEARING L R R	VISION DISTANT Uncorrected 6/6 Corrected 6/6			NEAR R L R L	Colour Vision N	Blood Group
164	75	27.4	136 86									
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS					N	A				
									7. Audiogram			
									8. Lung Function			
									9. Chest X-Ray			
									10. ECG			
									11. CVS risk for 40 yrs. & above			
									12. HIV, Hepatitis screening			

OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)

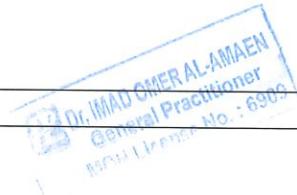
ASSESSMENT:

FIT ALL AREAS  FIT WITH RESTRICTION  TEMPORARY UNFIT  UNFIT

Date: 31/1/21 Name (Block Capitals): Dr. / Nurse



Signature:



REVIEW/CONSULTATION

Date: Name (Block Capitals): Dr. / Nurse Signature: