



PEACE LAND MEDICAL CENTER



MEDICAL EXAMINATION REPORT (CONFIDENTIAL)

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Surname
Forenames UTTAM SINGH
Address 101706721 - Truck owner
Home telephone number 98273072

Place of examination mta	Date 20/6/21
If a dependant enter employee's name here:	
Surname:	Forenames:
Birth date: 5/1/77	Nationality: Indian
Country of birth: India	Religion: Sikh
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced
Relationship to employee	
<input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	Number of children:
Reason for examination	Pre-Employment <input type="checkbox"/> Periodic medical check-up <input type="checkbox"/> Job: Operator
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	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 <input checked="" type="checkbox"/>
6. Hayfever /other significant allergy	26. Stroke since 4 years
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
HAVE YOU EVER BEEN:-	
41. Rejected for employment or insurance for medical reasons	
42. Awarded benefits for industrial injury/illness	
43. Treated for a mental condition, e.g. depression	
44. Treated for problem drinking or drug abuse	
45. Exposed to toxic substance or noise	
FOR WOMEN ONLY	
Have you ever had:-	
46. An abnormal smear	
47. Any gynaecological treatment	
48. Are you pregnant?	
49. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE	
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: 20/6/21	Signature of Applicant: Uttam Singh

On: Medications