



PEACE LAND MEDICAL CENTER

MEDICAL EXAMINATION REPORT (CONFIDENTIAL)

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Place of examination <u>MCT</u>		Date <u>25/5/21</u>																																																																																																																																																																																													
If a dependant enter employee's name here: Surname:																																																																																																																																																																																															
Birth date <u>3/2/59</u>	Nationality: <u>INDIAN</u>	Country of birth: <u>INDIA</u>																																																																																																																																																																																													
<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 checked="" type="checkbox"/> Son <input type="checkbox"/> Daughter																																																																																																																																																																																													
Reason for examination Pre-Employment <input checked="" type="checkbox"/> Periodic medical check-up <input type="checkbox"/> Pre-Overseas <input type="checkbox"/>		Job: <u>Operator</u> 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.)																																																																																																																																																																																															
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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: <u>25/5/21</u>		Signature of Applicant: <u>Dogindia</u>																																																																																																																																																																																													

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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	
<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
		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	WEIGHT kg	BMI	B.P.	PULSE	HEARING	VISION	Colour Vision	Blood Group
167	77	27.6	126/81	79 mins.	L N R A	DISTANT R L Uncorrected 6/6 6/6 Corrected	N	

N	A		LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A	
<input checked="" type="checkbox"/>		1. Urinalysis	Rt Mild Hearing Loss	<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 +)		<input checked="" type="checkbox"/>		11. CVS risk for 40 yrs. & above
<input checked="" type="checkbox"/>		6. Sickie Cell test		<input checked="" type="checkbox"/>		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: 25/5/2021

Name (Block Capitals): Dr. / Nurse

Signature:

REVIEW/CONSULTATION

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

Signature:

