



PEACE LAND MEDICAL CENTER

MEDICAL EXAMINATION REPORT (CONFIDENTIAL)

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Place of examination MCT		Date 25/5/21	Surname Togindar Ram																																																																						
If a dependant enter employee's name here: Surname:		Forenames Togindar Ram			Address 6056 5894 - Truck Oman																																																																				
Birth date 3/2/59	Nationality: INDIAN	Country of birth: INDIA	Religion: HINDU	Home telephone number 96339284 # 6676																																																																					
<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 type="checkbox"/> Daughter	Relationship to employee	Number of children 4																																																																					
Reason for examination	Pre-Employment <input checked="" type="checkbox"/> Periodic medical check-up <input type="checkbox"/>	Job: Operator			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"/>																																																																							
DO YOU HAVE OR HAVE YOU HAD:- (Tick "Yes" or "No" column or put a (?) if uncertain exclude minor ailments.)																																																																									
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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: 25/5/21		Signature of Applicant: Togindar X																																																																							



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	
	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.	PULSE	HEARING	VISION				Colour Vision	Blood Group
167	77	27.6	126 81	70 mins.	L N R A	DISTANT R L	NEAR R L			N	
					Uncorrected Corrected	6/6	6/6				

N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A
✓	1. Urinalysis	Re Mild Hearing Loss	✓	7. Audiogram
✓	2. Hb, Bloodcount, ESR		✓	8. Lung Function
✓	3. LFT, RFT, RBS		✓	9. Chest X-Ray
	4. Drug Screen		✓	10. ECG
✓	5. Lipids (40 years +)		✓	11. CVS risk for 40 yrs. & above
✓	6. Sickle Cell test			12. HIV, Hepatitis screening

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

ASSESSMENT:

FIT ALL AREAS

FIT WITH RESTRICTION

TEMPORARY LINEUP

100/100

Date: 25/5/20 Name:

Name (Block Capitals): Dr. / Nurse

Signature:

REVIEW/CONSULTATION

Date: _____ Name: _____

Name (Block Capitals): Dr. / Nurse

Signature:

