



MEDICAL EXAMINATION REPORT (CONFIDENTIAL)

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

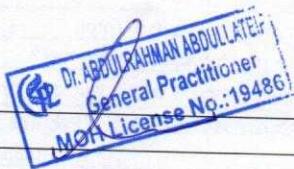
Place of examination <u>Mel</u>		Date <u>11/4/21</u>	Surname <u>MUHAMMAD SALEEM</u>																																																																																					
If a dependant enter employee's name here: Surname: <u></u>		Forenames <u></u>		Address <u>6778 - Premier Cognac</u>																																																																																				
Birth date: <u>11/02/78</u>		Nationality: <u>Pakistan</u>	Country of birth: <u>Pakistan</u>	Religion: <u>Muslim</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 checked="" type="checkbox"/> Daughter																																																																																					
Reason for examination		Pre-Employment <input type="checkbox"/>	Periodic medical check-up <input type="checkbox"/>	Job: <u>Operator</u>																																																																																				
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? <u>NO</u>		Average daily alcohol consumption <u>NO</u>																																																																																						
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: <u>11/4/21</u>	Signature of Applicant: <u>M. Saleem</u>																																																																																							



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. (MMHG)	PULSE 67 mins.	HEARING L R	VISION DISTANT R L					NEAR R L	Colour Vision	Blood Group	
162	60	22.9	127 84		N	Uncorrected	Corrected	6/6 6/6						N
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS												
1. Urinalysis														
2. Hb, Bloodcount, ESR														
3. LFT, RFT, RBS														
4. Drug Screen														
5. Lipids (40 years +)														
6. Sickle Cell test														
<i>mgm</i>														
OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.) <i>Address: Diet control & regular exercise</i>														
ASSESSMENT:														
<input checked="" type="checkbox"/> FIT ALL AREAS		<input type="checkbox"/> FIT WITH RESTRICTION		<input type="checkbox"/> TEMPORARY UNFIT		<input type="checkbox"/> UNFIT								
Date: 11/4/2021		Name (Block Capitals): Dr. / Nurse				Signature:								
REVIEW/CONSULTATION														
Date:		Name (Block Capitals): Dr. / Nurse							Signature:					

Date: 11/4/2021 Name (Block Capitals): Dr. / Nurse

Signature:

