



MEDICAL EXAMINATION REPORT (CONFIDENTIAL)

PLEASE COMPLETE YOUR PERSONAL  
DETAILS IN BLOCK CAPITALS

Surname
Forenames <b>MOHAMMAD SALEEM</b>
Address <b>6778 - Premier cognac</b>
Home telephone number <b>96548226</b>

Place of examination <b>mel</b>	Date <b>11/4/21</b>
If a dependant enter employee's name here: Surname:	
Birth date: <b>11/02/78</b>	Nationality: <b>Pakistane</b>
Forenames:	Country of birth: <b>Pakistan</b>
Religion: <b>Muslim</b>	Number of children: <b>5</b>
<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 type="checkbox"/> Periodic medical check-up <input type="checkbox"/> Pre-Overseas <input type="checkbox"/>	Job: <b>Operator</b> Area:

Name and address of family doctor	List your last 3 jobs (1) (2) (3)
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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.)

	Y	N		Y	N		Y	N
1. Sinus trouble			21. Cancer			HAVE YOU EVER BEEN:-		
2. Neck swelling/glands			22. Heart Disease			41. Rejected for employment or insurance for medical reasons		
3. Difficulty in vision			23. Rheumatic fever			42. Awarded benefits for industrial injury/illness		
4. Any ear discharge			24. Abnormal heartbeat			43. Treated for a mental condition, e.g. depression		
5. Asthma/bronchitis			25. High blood pressure			44. Treated for problem drinking or drug abuse		
6. Hayfever /other significant allergy			26. Stroke			45. Exposed to toxic substance or noise		
7. Any skin trouble			27. Serious chest pain			FOR WOMEN ONLY		
8. Tuberculosis			28. Any blood disease			Have you ever had:-		
9. Shortness of breath			29. Kidney disease			46. An abnormal smear		
10. Coughed/vomited blood			30. Blood in urine			47. Any gynaecological treatment		
11. Severe abdominal pain			31. Painful passage of urine			48. Are you pregnant?		
12. Stomach ulcer			32. Diabetes			49. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE		
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/arm/pit			40. Fear of heights					

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? ( )

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: <b>11/4/21</b>	Signature of Applicant: <b>M. Saleem</b>
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## 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	HEARING L R	VISION DISTANT R L NEAR R L Uncorrected Corrected	Colour Vision	Blood Group
162	60	22.9	127 84	67 mins.	N	6/6 6/6 6/6 6/6	N	

N	A		LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A	
/		1. Urinalysis		/		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 +)	mg/dl	/		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.)

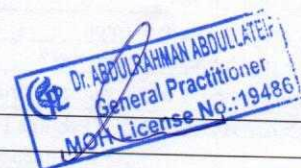
Admission: Diet control & regular exercise

### ASSESSMENT:

☒ FIT ALL AREAS ☐ FIT WITH RESTRICTION ☐ TEMPORARY UNFIT ☐ UNFIT

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

Signature:



### REVIEW/CONSULTATION

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

Signature: