INTEGRAL NOTES
ANNEX – C
A.O. No. 2013-0006

NAME OF CLINIC

DOH ACCREDITATION NUMBER
Clinic Address
Clinic Contact Information
Email Address

MEDICAL EXAMINATION REPORT FOR LANDBASED OVERSEAS WORKERS

Approved and authorized by the Department Of Health (DOH)

SURNAME/LAST NAME: SERRANO	GIVEN NAME: BERNARD		MIDDLE NAME: ABADILLA
AGE: 40	DATE OF BIRTH: 20 DAY / 9 MONTH / 1975 YEAR	PLACE OF BIRTH: PASIG CITY PH COUNTRY	NATIONALITY: FILIPINO
GENDER: MALE ☑ FEMALE ☐	CIVIL STATUS: SINGLE ☐ MARRIED ☑		RELIGION: ROMAN CATHOLIC
ADDRESS: 193 LUBYUTO ST. AYIZILUHNA AVE., PASIG CITY			
PASSPORT NUMBER: 420W33D	COUNTRY OF DESTINATION: SOUTH KOREA		
POSITION APPLIED FOR: GENEALOGIST	NAME OF COMPANY/ EMPLOYER/ RECRUITMENT AGENCY (WHENEVER APPLICABLE): SHUMOHUNG		

I. MEDICAL HISTORY - Has applicant suffered from, been diagnosed, sought advice or treatment from a medical doctor on the following conditions:
Place a check mark (✓) in the appropriate box ☐.

Head or Neck Injury YES ☐ NO ☐	Other Lung Disorders YES ☐ NO ☐	Gynaecological Disorders YES ☐ NO ☐	
Frequent Headaches YES ☐ NO ☐	High Blood Pressure YES ☐ NO ☐	Last Menstrual Period Specify date ____	
Frequent Dizziness YES ☐ NO ☐	Heart Disease/ Vascular/ Chest Pain YES ☐ NO ☐	Kidney or Bladder Disorder YES ☐ NO ☐	
Fainting Spells, Fits, Seizures or Other Neurological Disorders YES ☐ NO ☐	Rheumatic Fever YES ☐ NO ☐	Back Injury/Joint Pain/ Arthritis YES ☐ NO ☐	
Insomnia or Sleep Disorders YES ☐ NO ☐	Diabetes Mellitues YES ☐ NO ☐	Genetic, Hereditary or Familial Disorders YES ☐ NO ☐	
Depression, other Mental Disorders YES ☐ NO ☐	Other Endocrine Disorders (e.g. Goiter) YES ☐ NO ☐	Sexually Transmitted Diseases YES ☐ NO ☐	
Eye Problems/ Error of Refraction YES ☐ NO ☐	Cancer or Tumor YES ☐ NO ☐	Tropical Diseases (e.g. Malaria, Typhoid Fever – Specify Date) YES ☐ NO ☐	
Deafness, Other Ear Disorders YES ☐ NO ☐	Blood Disorders YES ☐ NO ☐	Schistosomiasis (Specify Date) YES ☐ NO ☐	
Nose or Throat Disorders YES ☐ NO ☐	Stomach Pain, Gastritis or Ulcer YES ☐ NO ☐	Asthma YES ☐ NO ☐	
Tuberculosis YES ☐ NO ☐	Other Abdominal Disorders YES ☐ NO ☐	Allergies (Specify) YES ☐ NO ☐	
		Operation(s) (Specify) YES ☐ NO ☐	

Place a check mark (✓) in the appropriate box ☐.

		YES	NO
1.	Have you ever been signed off as sick or repatriated from a jobsite overseas?	☐	☐
2.	Have you ever been hospitalized?	☐	☐
3.	Have you ever been declared unfit for work overseas?	☐	☐
4.	Has your medical certificate ever been restricted or revoked?	☐	☐
5.	Are you aware that you have any medical problem, disease or illness?	☐	☐
6.	Do you feel healthy and fit to perform the duties of your designated position/occupation?	☐	☐
7.	Are you allergic to any medication? Comments: ____	☐	☐
8.	Are you taking any non-prescription or prescription medication? If yes, please list the medication(s) taken/being taken, and the purpose(s) and dosage(s): ____	☐	☐