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: Dela Cruz	GIVEN NAME: Matt John		MIDDLE NAME: Samson
AGE: 22	DATE OF BIRTH: 7 (DAY) 10 (MONTH) 2001 (YEAR)	PLACE OF BIRTH: Manila (CITY) Philippines (COUNTRY)	NATIONALITY: Filipino
GENDER: MALE ☑ FEMALE ☐	CIVIL STATUS: SINGLE ☑ MARRIED ☐		RELIGION: Catholic
ADDRESS: 123 Bahay sa tabi St. Paco, Manila			
PASSPORT NUMBER: P1234567A	COUNTRY OF DESTINATION: USA		
POSITION APPLIED FOR: Site Engineer	NAME OF COMPANY/ EMPLOYER/ RECRUITMENT AGENCY (WHENEVER APPLICABLE): Company ABC		

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):	☐	☑