

Name:
Gender:
DOB:
Address:

Appointment code:



Medical Assessment

☐ Pre-employment

☐ Periodical

SECTION 1: Cardiovascular System

Height:		Weight:		BMI:	WHR:
Waist:		Hip:		BMI Classification:	WHR Classification:
Blood Pressure	mmHg	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>	<input type="checkbox"/> Underweight (<18.5) <input type="checkbox"/> Normal (18.5-24.9) <input type="checkbox"/> Overweight (25.0-29.9) <input type="checkbox"/> Obese (>30)		<input type="checkbox"/> Low Risk (Male<0.85, Female< 0.75) <input type="checkbox"/> Medium Risk (Male 0.85-0.95, Female 0.75-0.85) <input type="checkbox"/> High Risk (Male>0.95, Female>0.85)
Resting Heart rate	bpm	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>			
Heart Sounds		Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>			
Peripheral Vessels		Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>			
Veins & other Vessels		Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>			

Examiner Comments

SECTION 2: Visual Acuity

Candidate should be tested wearing visual aids if routinely worn

	Right	Right corrected	Left	Left Corrected
Distance Vision	6/	6/	6/	6/
Near Vision	N/	N/	N/	N/
Colour Vision (Ishihara Test)	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Score: /17			
Peripheral Vision	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>			
Visual Aids to be worn at work?	Yes <input type="checkbox"/> No <input type="checkbox"/>			

Examiner Comments

SECTION 3: Urinalysis

Protein	<input type="checkbox"/> Nil	<input type="checkbox"/> Trace	<input type="checkbox"/> +	<input type="checkbox"/> ++	<input type="checkbox"/> +++	Blood Sugar Level mmol/L
Glucose	<input type="checkbox"/> Nil	<input type="checkbox"/> Trace	<input type="checkbox"/> +	<input type="checkbox"/> ++	<input type="checkbox"/> +++	
Blood	<input type="checkbox"/> Nil	<input type="checkbox"/> Trace	<input type="checkbox"/> +	<input type="checkbox"/> ++	<input type="checkbox"/> +++	

Examiner Comments

Fix Label Here

Medical Assessment

SECTION 4: Respiratory System	
Spirometry (see attached)	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>
Symmetrical Chest expansion	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>
Auscultation	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>
SECTION 5: Ear, Nose, Throat & Mouth	
Ears	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>
Hearing (Refer to Audiogram)	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>
Nose	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>
Throat	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>
Teeth and gums	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>
SECTION 6: Skin	
Evidence of Skin Disorders (Eczema/dermatitis/ sun damage / other)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Evidence of drug/alcohol abuse	Yes <input type="checkbox"/> No <input type="checkbox"/>
Evidence of nail biting	Yes <input type="checkbox"/> No <input type="checkbox"/>
Evidence of Scars (Surgical or other)	Yes <input type="checkbox"/> No <input type="checkbox"/>
SECTION 7: Gastrointestinal & Urinary System	
Abdomen	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>
Hernial Orifices	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>
Liver	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>
Spleen	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>
Kidneys	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>
SECTION 8: Nervous System	
Balance & reflexes	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>
Coordination	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>
SECTION 9: Glandular	
Lymph glands	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>
Thyroid	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>
Examiner Comments	

Fix Label Here

Medical Assessment

SECTION 10: Cardiovascular Risk Assessment			
AGE:			
Risk Factor Checklist		Risk Stratification	
<input type="checkbox"/> Hypertension (>150/95 mmHg)		<input type="checkbox"/> LOW	≤ 1 risk factors
<input type="checkbox"/> Current Smoker		<input type="checkbox"/> MEDIUM	≥ 2 risk factors
<input type="checkbox"/> Known High Cholesterol			
<input type="checkbox"/> Sedentary Lifestyle			
<input type="checkbox"/> Family History of Heart Disease			
<input type="checkbox"/> History of Heart Disease		<input type="checkbox"/> HIGH	Diagnosed cardiac, pulmonary or metabolic disease OR ≥ 1 sign or symptom of Coronary Artery Disease*
<input type="checkbox"/> WHR >0.80 (Women)			
>0.90 (Men) AND Obesity (BMI ≥ 30)			
GP Clearance to complete exercise testing (if required)			Yes <input type="checkbox"/> No <input type="checkbox"/>
<p>*Signs and symptoms include: pain or discomfort(or angina equivalent) in the chest, neck, jaw, arms, or other areas that may result from ischemia; dizziness or syncope; shortness of breath at rest or with exertion; ankle edema; palpitations or tachycardia; intermittent claudication; known heart mummer; unusual fatigue or shortness of breath with usual activities; orthopnoea or paroxysmal nocturnal dyspnoea.</p>			
Doctor's Name		Signature	
Date		Location	