

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
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## 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		

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## Medical Assessment

SECTION 10: Cardiovascular Risk Assessment			
<b>AGE:</b>			
<b>Risk Factor Checklist</b>		<b>Risk Stratification</b>	
<input type="checkbox"/> Hypertension (>150/95 mmHg)		<input type="checkbox"/> <b>LOW</b>	≤ 1 risk factors
<input type="checkbox"/> Current Smoker		<input type="checkbox"/> <b>MEDIUM</b>	≥ 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"/> <b>HIGH</b>	Diagnosed cardiac, pulmonary or metabolic disease <b>OR</b> ≥ 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>			
<b>Doctor's Name</b>		<b>Signature</b>	
<b>Date</b>		<b>Location</b>	