

**A Type Of Health Screening**Periodical Pre-Employment 40 Yrs or below M FAbove 40 Yrs M F

Pre-employment & Periodic Health Examination								Pre-employment - Additional Test
Tests	Blood	Urine	Stool	Audiometry	Chest X-ray	ECG	Vision/Eye	Drug screening
Check for Completion								
Additional Health Screening above 40 Yrs - Pre-employment & Periodic Health Examination								
Tests	Tonometer	CEA	TSH	Alkaline Phosphate	USG (Abdomen)	PFT	Cardiac Stress test	Additional Test - Males Above 40 Yrs
Check for Completion								PSA
								Prostate Ultrasound
								Mammogram
								PAP Smear (Optional)

B Personal Information

Name _____

Nationality _____

Gender M F

Company Name _____

Date of Birth DD MM YY YY

Work Location _____

Employee No. _____

E-mail Address _____

Job Title _____

Contact No. _____

City _____

Contact Address _____

C Medical History: Please answer the following to the best of your knowledge

Is there any past/present history of any of the following

Candidates

- 1) Ear / Nose / Throat Problem Y N
- 2) Allergy / Hay Fever Y N
- 3) Skin Disease / Psoriasis Y N
- 4) Hearing Impairment/Ear Discharge Y N
- 5) Heart Disease Y N
- 6) Stomach / Bowel Disorders Y N
- 7) Gall Stones / Kidney Disorders Y N
- 8) Fits / Epilepsy / Dizziness / Fainting Y N
- 9) Head Injury / Concussion / Loss of Memory Y N
- 10) Nervous / Mental disease / Sleep disorder Y N
- 11) Headaches / Migraine Y N
- 12) Piles / Varicose veins Y N
- 13) Blood Disorder Y N
- 14) Female Disorders Y N
- 15) Allergies / Current Medications : Y N

Is there any past/present history of any of the following

Candidates

- 16) Eye / Vision Problems / Glaucoma Y N
- 17) Asthma / Bronchitis / Tuberculosis Y N
- 18) High/Low Blood Pressure Y N
- 19) Diabetes Y N
- 20) Jaundice / Liver Disease Y N
- 21) Fracture / Dislocation / Injury / Amputation Y N
- 22) Joint Pain/Spinal Trouble Y N
- 23) Major / Minor Operation Y N
- 24) Infection / Contagious Disease Y N
- 25) Addiction to alcohol / drugs / tobacco Y N
- 26) Malignant Disease (Cancer) Y N
- 27) Hernia / Hydrocoele / Appendicitis Y N
- 28) Lump In breast/Gynecological treatment Y N
- 29) Signed off on medical ground/Declared Unfit Y N

Please include any other medical condition that may not have been mentioned:

D Occupational History : (Have you been exposed to)a) Mercury Y Nb) Radioactivity Y Nc) Excessive noise Y Nd) Toxic Chemicals Y Ne) Any other occupational hazard Y N

If Yes please specify _____

E FAMILY HISTORY:



To be completed by Hospital/Medical Center

F PHYSICAL EXAMINATION

a) Height (cms)	<input type="text"/>	<input type="text"/>	b) Weight (Kgs)	<input type="text"/>	<input type="text"/>	<input type="text"/>	c) Pulse (/Min)	<input type="text"/>	<input type="text"/>	<input type="text"/>				
d) Temperature	<input type="text"/>	<input type="text"/>	f) Respiratory rate	<input type="text"/>	<input type="text"/>	<input type="text"/>	e) Blood Pressure	Systolic	<input type="text"/>	<input type="text"/>	Diastolic	<input type="text"/>	<input type="text"/>	<input type="text"/>

G SYSTEMIC EXAMINATION (Please Tick the Normal / Abnormal)

	Normal	Abnormal	Comments		Normal	Abnormal	Comments
a) Head & Neck	<input type="checkbox"/>	<input type="checkbox"/>		i) Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	
b) Ears / Nose / Throat	<input type="checkbox"/>	<input type="checkbox"/>		j) Respiratory System	<input type="checkbox"/>	<input type="checkbox"/>	
c) Eyes	<input type="checkbox"/>	<input type="checkbox"/>		k) Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	
d) Teeth Cavity & Oral	<input type="checkbox"/>	<input type="checkbox"/>		l) Genito-urinary system	<input type="checkbox"/>	<input type="checkbox"/>	
e) Lungs & Chest	<input type="checkbox"/>	<input type="checkbox"/>		m) Skin and varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	
f) Cardiovascular System	<input type="checkbox"/>	<input type="checkbox"/>		n) Anus & Rectum	<input type="checkbox"/>	<input type="checkbox"/>	
g) Neurological	<input type="checkbox"/>	<input type="checkbox"/>		o) Hernia	<input type="checkbox"/>	<input type="checkbox"/>	
h) Breast	<input type="checkbox"/>	<input type="checkbox"/>					
Others:	<input type="checkbox"/>	<input type="checkbox"/>					

H INVESTIGATIONS	H1-H2 Audiometry	Normal	Abnormal	Low (0.5,1,2 kHz)	High (3,4,6 kHz)
1) H1-H2 Audiometry	Right Ear				
	Left Ear				

2) Vision	Vision	Distance	With Correction	Near	With Correction
	Right Eye	/6		N	
	Left Eye	/6		N	
				Normal	Abnormal
	Right Visual Fields				
	Left Visual Fields				
Colour Blindness- Ishihara					

3) Cardiac Function	Normal	Abnormal	Remarks
	ECG General	<input type="checkbox"/>	<input type="checkbox"/>

4) Imaging	Normal	Abnormal	Remarks
	Chest X-ray	<input type="checkbox"/>	<input type="checkbox"/>

5) Urine	Normal	Abnormal		F) Stool	Normal	Abnormal		
	Albumin	<input type="checkbox"/>			<input type="checkbox"/>	Parasite	<input type="checkbox"/>	<input type="checkbox"/>
	Sugar	<input type="checkbox"/>			<input type="checkbox"/>	Blood	<input type="checkbox"/>	<input type="checkbox"/>
	Blood	<input type="checkbox"/>			<input type="checkbox"/>	Others	<input type="checkbox"/>	<input type="checkbox"/>
	Others	<input type="checkbox"/>			<input type="checkbox"/>			

6) BLOOD TEST	Normal	Abnormal	Remarks
	<input type="checkbox"/>	<input type="checkbox"/>	

7) DRUG SCREENING (Pre - Employment only)	Normal	Abnormal	Remarks
	<input type="checkbox"/>	<input type="checkbox"/>	

FOR ALL CANDIDATE ABOVE 40 Yrs	Normal	Abnormal	Remarks	
	8) Tonometry	<input type="checkbox"/>	<input type="checkbox"/>	
	9) CEA (carcinoembryonic Ant)	<input type="checkbox"/>	<input type="checkbox"/>	
	10) TSH	<input type="checkbox"/>	<input type="checkbox"/>	
	11) Alkaline Phosphatase	<input type="checkbox"/>	<input type="checkbox"/>	



To be completed by Hospital/Medical Center

12) USG (abdomen & Pelvis)	Normal	Abnormal	Remarks	
13) Spirometry (PFT)				
14) Cardiac Stress test				
Additional For MEN ABOVE 40 Yrs	Normal	Abnormal	Remarks	
15) PSA				
16) Prostate Ultrasound				
Additional For WOMEN	Normal	Abnormal	Remarks	
17) Mammogram				
18) PAP Smear (optional)				
I Health parameter checked	Normal	Abnormal	Remarks	
GENERAL CONDITION				
COMPLETE BLOOD COUNT				
HYPERTENSION				
CARDIAC STATUS				
EYE/VISION CHECKS				
EAR/HEARING				
LIPID PROFILE				
LIVER PROFILE				
RENAL PROFILE				
RESPIRATORY (SPIROMETRY)				
SEROLOGY				
DRUG TEST				
USG				
X-RAY				
URINE				
STOOL				
FEMALE SPECIFIC TEST				
COMMENT BY EXAMINING PHYSICIAN:				
FIT IN ALL AREAS		<input type="checkbox"/> Y	<input type="checkbox"/> N	
FURTHER ASSESSMENT IF REQUIRED		<input type="checkbox"/> Y	<input type="checkbox"/> N	(if yes please comment)
RESTRICTION REQUIRED		<input type="checkbox"/> Y	<input type="checkbox"/> N	(if yes please comment)
COMMENT : (UNFIT/ FURTHER ASSESSMENT/RESTRICTION REQUIRED)				
DETAILS OF EXMINING PHYSICIAN			Stamp / seal	
Doctor's Name :				
Clinic Name :				
Address :				
Signature & Date:				