

A Type Of Health Screening

Periodical ☐ Pre-Employment ☐ 40 Yrs or below ☐ M ☐ F Above 40 Yrs ☐ M ☐ F

n for	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								Additional Test - Males Above 40 Yrs	Additional Test - Females Above 40 Yrs		
	Tests	Tonometry	CEA	TSH	Alkaline Phosphate	USG (Abdomen)	PFT	Cardiac Stress test	PSA	Prostate Ultrasound	Mammogram	PAP Smear (Optional)
	Check for Completion											

B Personal Information

Name Nationality

Gender ☐ M ☐ F Company Name

Date of Birth DD MM 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 / Migrane ☐ 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 ☐ N b) Radioactivity ☐ Y ☐ N c) Excessive noise ☐ Y ☐ N d) Toxic Chemicals ☐ Y ☐ N

e) 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"/>	<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"/>	<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"/>

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
1) H1-H2 Audiometry

H1-H2 Audiometry	Normal	Abnormal	Low (0.5,1,2 kHz)	High (3,4,6 kHz)
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"/>	<input style="width: 100%;" type="text"/>

4) Imaging

	Normal	Abnormal	Remarks
Chest X-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 100%;" type="text"/>

5) Urine

	Normal	Abnormal
Albumin	<input type="checkbox"/>	<input type="checkbox"/>
Sugar	<input type="checkbox"/>	<input type="checkbox"/>
Blood	<input type="checkbox"/>	<input type="checkbox"/>
Others	<input type="checkbox"/>	<input type="checkbox"/>

F) Stool

	Normal	Abnormal
Parasite	<input type="checkbox"/>	<input type="checkbox"/>
Blood	<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"/>	<input style="width: 100%;" type="text"/>

**7) DRUG SCREENING
(Pre - Employment only)**

	Normal	Abnormal	Remarks
	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 100%;" type="text"/>

FOR ALL CANDIDATE ABOVE 40 Yrs

	Normal	Abnormal	Remarks
8) Tonometry	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 100%;" type="text"/>
9) CEA (carcinoembryonic Ant	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 100%;" type="text"/>
10) TSH	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 100%;" type="text"/>
11) Alkaline Phosphatase	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 100%;" type="text"/>

To be completed by Hospital/Medical Center

	Normal	Abnormal	Remarks
12) USG (abdomen & Pelvis)	<input type="text"/>	<input type="text"/>	<input type="text"/>
13) Spirometry (PFT)	<input type="text"/>	<input type="text"/>	<input type="text"/>
14) Cardiac Stress test	<input type="text"/>	<input type="text"/>	<input type="text"/>
Additional For MEN ABOVE 40 Yrs			
	Normal	Abnormal	Remarks
15) PSA	<input type="text"/>	<input type="text"/>	<input type="text"/>
16) Prostate Ultrasound	<input type="text"/>	<input type="text"/>	<input type="text"/>
Additional For WOMEN			
	Normal	Abnormal	Remarks
17) Mammogram	<input type="text"/>	<input type="text"/>	<input type="text"/>
18) PAP Smear (optional)	<input type="text"/>	<input type="text"/>	<input type="text"/>
I Health parameter checked	Normal	Abnormal	Remarks
GENERAL CONDITION	<input type="text"/>	<input type="text"/>	<input type="text"/>
COMPLETE BLOOD COUNT	<input type="text"/>	<input type="text"/>	<input type="text"/>
HYPERTENSION	<input type="text"/>	<input type="text"/>	<input type="text"/>
CARDIAC STATUS	<input type="text"/>	<input type="text"/>	<input type="text"/>
EYE/VISION CHECKS	<input type="text"/>	<input type="text"/>	<input type="text"/>
EAR/HEARING	<input type="text"/>	<input type="text"/>	<input type="text"/>
LIPID PROFILE	<input type="text"/>	<input type="text"/>	<input type="text"/>
LIVER PROFILE	<input type="text"/>	<input type="text"/>	<input type="text"/>
RENAL PROFILE	<input type="text"/>	<input type="text"/>	<input type="text"/>
RESPIRATORY (SPIROMETRY)	<input type="text"/>	<input type="text"/>	<input type="text"/>
SEROLOGY	<input type="text"/>	<input type="text"/>	<input type="text"/>
DRUG TEST	<input type="text"/>	<input type="text"/>	<input type="text"/>
USG	<input type="text"/>	<input type="text"/>	<input type="text"/>
X-RAY	<input type="text"/>	<input type="text"/>	<input type="text"/>
URINE	<input type="text"/>	<input type="text"/>	<input type="text"/>
STOOL	<input type="text"/>	<input type="text"/>	<input type="text"/>
FEMALE SPECIFIC TEST	<input type="text"/>	<input type="text"/>	<input type="text"/>
COMMENT BY EXAMINING PHYSICIAN:			
<div style="display: flex; justify-content: space-between;"> <div> FIT IN ALL AREAS <div style="display: flex; gap: 10px;"> <input type="text" value="Y"/> <input type="text" value="N"/> </div> </div> <div> FURTHER ASSESSMENT IF REQUIRED <div style="display: flex; gap: 10px;"> <input type="text" value="Y"/> <input type="text" value="N"/> </div> <div style="border: 1px solid black; padding: 5px; width: 400px; margin-top: 5px;"> (if yes please comment) </div> </div> <div> RESTRICTION REQUIRED <div style="display: flex; gap: 10px;"> <input type="text" value="Y"/> <input type="text" value="N"/> </div> <div style="border: 1px solid black; padding: 5px; width: 400px; margin-top: 5px;"> (if yes please comment) </div> </div> </div>			
COMMENT : (UNFIT/ FURTHER ASSESSMENT/RESTRICTION REQUIRED)			
DETAILS OF EXMINING PHYSICIAN Doctor's Name : Clinic Name : Address : Signature & Date:			<div style="border: 1px solid black; padding: 10px; height: 50px;"> Stamp / seal </div>