SIEMENS

PRE - EMPLOYMENT MEDICAL EXAMINATION RECORD

MEDICAL & OCCUPATIONAL HEALTH SERVICES	WORKS		PERM.	
	OFFICE		TEMP.	

PHOTO

DATE	PME No.	PRE No.	T. No.

FOR OFFICE USE ONLY

NAME	AGE	MALE ☐
IDENTIFICATION MARK	DOB	FEMALE ☐

PRESENT HISTORY OF ILLNESS & MEDICATIONS (if any)

PAST HISTORY OF MAJOR ILLNESS / SURGERY

PERSONAL HABIT

- ☐ SMOKING
- ☐ ALCOHOL
- ☐ MEDICATION
- ☐ TOBACCO CHEWING
- ☐ DIET VEG./NON-VEG.
- ☐ BOWEL HABITS REGULAR Y/N
- ☐ OTHERS

MARTIAL STATUS

- ☐ SINGLE
- ☐ MARRIED
- ☐ WIDOWED
- ☐ DIVORCED

NO. OF CHILDREN

MALE :

FEMALE :

F. P HISTORY

HAVE YOU OR ANY MEMBER OF YOUR FAMILY (SPOUSE, CHILDREN, BROTHERS, SISTERS, PARENTS ETC.) IN THE PAST SUFFERED FROM ANY OF THE ILLNESS GIVEN BELOW:

DISEASE	YES	NO	*RELATION	DISEASE	YES	NO	*RELATION
ASTHMA				ARTHRITIS / GOUT			
RECURRENT EAR, NOSE & THROAT PROBLEDM				ACCIDENTS / INJURIES SURGICAL OPERATIONS			
EOSINOPHILIA				THYROID ENLARGEMENT			
DIABETES				EYE PROBLEM / VISUAL DISTURBANCE			
HYPERTENSION				TUBERCULOSIS			
HEART DISEASE				MALARIA			
STROKE / PARALYSIS				LEPROSY			
VERTIGO				TYPHOID			
EPILEPSY				KIDNEY/URINARY AILMENT			
MENTAL DISORDER				RECURRENT HEADACHES			
PEPTIC ULCER				CANCER			
JAUNDICE				ALLERGIES - DRUGS OR FOOD ITEMS			
CHRONIC DYSENTRY				SKIN DISORDERS			
CHRONIC BACKACHES				OCCUPATIONAL HEALTH AILMENT			
ANY OTHER (SPECIFY),							

* IF ANSWER IS YES, PLEASE INDICATE WHETHER FOR SELF, SPOUSE OR CHILDREN, BROTHERS, SISTERS OR PARENTS

FOR FEMALE CANDITATES ONLY

	YES	NO		YES	NO
EXCESSIVE OR IRREGULAR MENSTRUAL PERIODS			LUMP IN THE BREAST		
STATE OF PREGNANCY (IF APPLICABLE)			GYNAEC SURGERY		
ANY COMPLICATIONS DURING PREGNANCY			WHETHER ON ORAL PILLS		

IF THE ANSWER IS 'YES' TO ANY OF THE ABOVE QUESTIONS, PLEASE GIVE DETAILS REGARDING NATURE OF ILLNESS, DURATION AND YEAR OF OCCURANCE :

PRESENT JOB DESCRIPTION (SIEMENS)	PREVIOUS NATURE OF JOBS (IF ANY)			
	NAME OF COMPANY/ ORGANISATION	PERIOD (FROM - TO)	NATURE OF JOB	ANY OCCUPA-TIONAL AILMENT
DESIGNATION :				
CADRE :				
DEPT. / UNIT :				
PC/CC :				
REPORTING TO :				
QUALIFICATION :				

DECLARATION BY THE CANDIDATE

I DECLARE THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

I CERTIFY THAT I HAVE NOT RECEIVED A DISABILITY CERTIFICATE / PENSION OR COMPENSATION ON ACCOUNT OF ANY DISEASE OR OTHER CONDITION.

DATE :

PLACE :

CANDIDATE'S SIGNATURE