Form E: Pre-Employment Medical Screening for Industrial Workforce

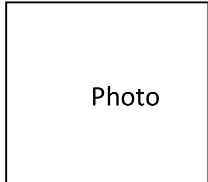
Instructions for applicants

All applicants who are being considered by a prospective employer for employment in the industries are required to undertake a pre-employment medical screening.

The following forms are required to be completed accurately and in full by both the applicant and the medical or health person prior to medical assessment and certification.

The completed forms must be returned to the prospective employer and a copy is retained with the issuing authority.

Section A: Applicant's report (*to be completed by the applicant*)



Part I: Personal detail

Surname:______________________ First Name:_________________________
Nationality: _______________________________ DoB: ___________________________
Address: ____
Employer: __________________________________ Contact No: _________________________

Part II: **Personal Medical History**

	Yes	No	If yes, give details
Are you currently being treated by any doctor for any illness?	☐	☐	______________________________
Are you currently taking any medications including inhaler?	☐	☐	_____________________________
Are you allergic to anything?	☐	☐	_____________________________
Have you ever spent time in hospital as a patient?	☐	☐	______________________________
Have you broken or fractured any bones?	☐	☐	_______________________________
Have you ever had a disease or injury resulting from work?	☐	☐	_______________________________
Do you suffer from back, neck or spinal problems?	☐	☐	_______________________________
Have you ever had an X-Ray or scan on neck or back?	☐	☐	______________________________
Have you, in the last 2 years, lost time from work because of illness or injury?	☐	☐	_____________________________
Have you been exposed to any toxic substances or environmental Hazards?	☐	☐	__________________________

Part III: Do you now, or have you ever had any of the following? (Please tick box)

Yes	No		Yes	No		Yes	No	
☐	☐	Hernia	☐	☐	Dermatitis/eczema/psoriasis	☐	☐	Head injury or concussion
☐	☐	Rheumatic fever	☐	☐	Ear ache or discharging ears	☐	☐	Deep vein thrombosis
☐	☐	Hay fever/allergies	☐	☐	Hearing defects	☐	☐	Foot trouble
☐	☐	Asthma	☐	☐	Depression	☐	☐	Passing blood in urine/stool
☐	☐	Chest pain	☐	☐	Anxiety/stress	☐	☐	Frequent migraine headaches
☐	☐	Palpitation/irregular Heart beats	☐	☐	Other mental disorders	☐	☐	Other joint injuries or condition
☐	☐	Shortness of breath	☐	☐	Blackouts/fainting	☐	☐	Ankle or knee troubles
☐	☐	High Blood pressure	☐	☐	Hepatitis/jaundice	☐	☐	Bruising or excessive
☐	☐	Back pain, back injury, Sciatica	☐	☐	Vomiting blood	☐	☐	Injury requiring an operation
☐	☐	Eye trouble	☐	☐	Kidney disease/bladder problems	☐	☐	Cancer or tumor of any kind
☐	☐	Epilepsy/fits	☐	☐	Diabetes	☐	☐	Leprosy/TB/Kalazar

Comment: ____

____

Is there any history of serious disease or illness in your immediate family Yes ☐ No ☐

If yes please provide details when you see the doctor

Do you

Yes	No		
☐	☐	Smoke or have you ever smoked. If yes, no. of cigarettes per day	______________________
☐	☐	Take illicit drugs, if yes provide details	______________________
☐	☐	Drink alcohol, if yes average number of standard drinks per week	______________________
☐	☐	Have any illness or injuries not stated above, if yes provide details	______________________

Do you have difficulty in any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Crouching/bending/kneeling	☐	☐	Walking on uneven Ground	☐	☐	Standing for an extended periods of time
☐	☐	Lifting heavy weights	☐	☐	Sitting for extended Period of time	☐	☐	Repetitive movements of hands/arms
☐	☐	Working at heights	☐	☐	Shift/work/sleep	☐	☐	confined spaces
☐	☐	Walking upstairs/ladders	☐	☐	Working in hot/cold Extremes	☐	☐	Working above shoulder height

When and where was your last chest X-ray taken? ______________________________________

When was your last Td injection? ______________________________________

Do you have or have ever had any other conditioned above that may impact on your ability to safely perform the duties required to you?

I hereby certify that the foregoing particulars are to the best of my knowledge correct. I authorize to release any information acquired from this examination to my employer/ prospective employer or their authorized representative.

Signature and date

Signature of witness and date

Section B; Medical examination (to be completed by a registered medical or health person)

1. Measurements

Height ____________________ Weight ________________________ BMI (if required) ______________________

Visual acuity:

Distance Vision

Eye	Uncorrected	Corrected
Right		
Left		
Both		

Close Vision

Corrected	Uncorrected
N	N
N	N
N	N

Colour Vision: Normal ☐ Abnormal ☐

Blood pressure: ……………… mmHg Additional readings if required: ……………………

Pulse rate (resting pulse) ………………….. per min; Rhythm: Regular ☐ Irregular ☐

2. General:

		Yes	No	Provide details if required
a)	Does the appearance correspond with the age stated?	☐	☐	___________________________________
b)	Is there anything unfavorable in appearance	☐	☐	___________________________________
c)	Give particulars of permanent marks or scars	☐	☐	__________________________________
d)	Any dermatitis, skin rash, infection	☐	☐	____
e)	Any swelling/pitting pedal oedema	☐	☐	____

3. Respiratory system:

		Yes	No	Provide details if required
a)	Is breathing normal and regular in character?	☐	☐	____________________________________
b)	Is there any abnormality on inspection or examination?	☐	☐	__________________________________
c)	See is there any sign of past or present respiratory disease	☐	☐	______________________________________

4. Circulatory system:

		Yes	No	Provide details if required
a)	Are there any abnormalities on cardiac auscultation?	☐	☐	____
b)	Is there any abnormality in the heart rate or rhythm?	☐	☐	____
c)	Is there any varicose veins?	☐	☐	____

5. Digestive system:

		Yes	No	Provide details if required
a)	Is there evidence of abnormality of the tongue, mouth, teeth or throat?	☐	☐	____
b)	Is there evidence of abnormality for abdominal organs, including liver and spleen?	☐	☐	____
c)	Is a hernia present?	☐	☐	____

6. Spine and nervous system

		Yes	No	Provide details if required
a)	Is there evidence of disease of the brain or spinal cord?	☐	☐	____
b)	Is there any defect in sight, hearing or speech?	☐	☐	____
c)	Is the evidence of abnormality for:			
	Shoulder	☐	☐	______________________________________
	Elbows/wrist	☐	☐	____
	Hand/hips	☐	☐	____
	Knees/ankles	☐	☐	____
	Feet	☐	☐	____
	Cervical spine	☐	☐	____
	Thoracic spine	☐	☐	____

d) Reflexes:
Is there evidence of abnormality for:

Biceps	☐	☐	________________
Triceps	☐	☐	________________
Supinator	☐	☐	________________
Knee	☐	☐	________________
Ankle	☐	☐	________________

7. Hearing Test: *(Note the findings)*

Ear	External appearance	Auroscopic exam	Rinne's test	Weber's test	Conversational hearing/whispering test	Audiometry *(please attach report)*
Right						
Left						

Normal ▫Abnormal ▫ If abnormal, give details………………………………………………………………..

7. For female candidates

a) **Menstrual history:** Menarche at ……….. yrs (age) LMP………………………….
Menstrual irregularity, if any ……………………………………..

b) **Obstetric history**: Gravida ……………. . Para…………………………….

c) Pel**vic examination** *(for married women only)*…………………………………………….

d) Pap smear…………………………….

e) Pregnancy test…………………….

Investigations:

a) Serological Examination
Hepatitis B……………. Hepatitis C…………… HIV ……………. RPR ……………. TPHA ………

b) CBC
TLC……………….. DLC……………………. Hb …………………..

c) ABO Rh ………………

d) Smear for malaria …………………

e) Urine analysis: Sugar ………………….. Protein ……………….. Blood …………..

f) Electrocardiogram (if required) Normal ☐ Abnormal ☐ Report attached☐

g) Chest x-ray: Film No. Normal ☐Abnormal ☐ Report attached ☐

h) Pulmonary Function test (where indicated):

	FVC	FEV1
Predicted		
Measured		
% of predicted		

Remarks: ……………………………………………………………

i) Additional investigations for persons over 40 years of age (male):
TMT
Echocardiogram
Ultrasound for prostrate

Section C:
I am of the opinion that the above mention person is :

☐ Fit for proposed employment

☐ Fit for proposed employment with the following restrictions;
____

☐ Unfit for proposed employment

______________________________________ MBHC Reg. No
Signature and Name of the Medical or health person ---------------

Date: ………………………………… Official seal