

**PAN AFRICAN POSTAL UNION**

**MEDICAL EXAMINATION REPORT FORM**

**DATE**: ………./………../………..

**NAME/DR/MR/MRS/MISS**: ……………………………………………………………………………………………..

**DATE OF BIRTH** :……………………………………  **SEX** : ……………………………………………………...

**FAMILY MEDICAL HISTORY**: ……………………………………………………………………………………..

**PERSONAL MEDICAL HISTORY**:

1. HEREDITARY OR CONGENITAL CONDITIONS ……………………………………………
2. SERIOUS OR CHRONIC DISEASES ...………………………………………………………..
3. ACCIDENTS ……………………………………………………………………………..............
4. SURGICAL OPERATON …………………………………………………………………………
5. HOSPITALIZATION ………………………………………………………………………………
6. WEIGHT CHANGE IN PAST YEAR …………………………...………………………............
7. SKIN INFECTIONS ……………………………………………...………………………...……...

**PRESENT CONDITION**:

1. **GENERAL CONDITION** …………………………………………………………………...……………….

………………………………………………………………………………………………………………….

HEIGHT ……………...………… WEIGHT ….……………..………. SKIN ...………………………

1. **DIGESTIVE SYSTEM**

TEETH ……………………………………………….TONGUE …………………………..………………

ABDOMEN ………………………………………………………………………………………………

LIVER ………………………………………SPLEEN …………………………………………..

HERNIA ………………………………………RECTAL EXAMINATION………………………...

1. **CIRCULATORY SYSTEM**

PULSE …………………………………………….. BLOOD PRESSURE ……………………………...

AUSCULTATION ……………………………………………………………………………………..……..

APEX BEAT …………………………………………VESSELS ………………………………………….

1. **RESPIRATORY SYSTEMS**

NOSE ……………………………………………… THROAT ……………………………………..

CHEST ……………………………………………………………………………………………………..

AUSCULTATION……………………………………………………………………………………………

1. **AUDITORY SYSTEM**

EARS …………………………………………………………………………………………………………

|  |  |
| --- | --- |
| **HEARING** | **DRUMS** |

RIGHT …………………………………………………………………………………………………………………

LEFT …………………………………………………………………………………………………………………..

1. VISION

EYES ………………………………………………………………………………………………….…………………..

ACUITY (CORRECTED) ……………………………….. (UNCORRECTED) ………………………………………

FIELDS …………………………………………………… COLOUR …………………………………………………

1. GENITOURINARY SYSTEM

GENITALIA ……………………………………………… KIDNEYS ………………………………………………..

FOR WOMEN – L.M.P. ………………………………… PARA …………………………………………………….

P.V. ………………………………………………………. BREASTS …………………..……………………………

PAP SMEAR IF POSSIBLE ……………………………………………………………………………………………

1. LOCOMOTOR SYSTEM

LIMBS …………………………………………………………………………………………………………………….

GAIT ……………………………………………………... DEFORMITY ……………………...................................

1. NERVOUS SYSTEM

TEMPERAMENT ……………………………………………………………………………………………….………..

MENTAL STATUS …………………………………………………………………………………………...…..………

CRANIAL NERVES ……………………………………………………………………………………...…………..….

SUPERFICIAL REFLEXES ……………………………………………………………………………..…………..….

……………………………………………………………………………………………………………………………..

1. INVESTIGATION (PLEASE FORWARD ALL FILMS AND REPORTS)

CHEST X-RAY ………………………………………………………………………………………….…….………….

ELECTROCARDIOGRAM ……………………………………………………………………………..……………….

STOOL EXAMINATION ………………………………………………………………………………..….…………….

URINE ANALYSIS ………………………………………………………………………………….…..………………..

BLOOD

HAEMORGRAM …………………………………………………………………………………………..…..

SEROLOGY (KHAN/VORL) …………………………………………………………………………..…..…

BIOCHEMISTRY (LIVER/KIDNEY FUNCTION TESTS, URIC ACID, BLOOD SUGAR ETC)

…………………………………………………………………………………………………………..………

HAEMGLOBIN ELECTROPHORESIS …………………………………………………..…………………

(**11**) OTHERS AS INDICATED

………………………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………………

(**12**) OPINION

I CERTIFY TO THE BEST OF MY KNOWLEDGE THAT I HAVE EXAMINED

DR/MR/MRS/MISS ………………………………………………………………………………………………… AND FOUND

HIM/HER TO BE MEDICALLY FIT/UNFIT FOR EMPLOYMENT HE/SHE IS ON/NOT ON TREATMENT (SPECIFY)

……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

DATE ………….…./………….…../……………….

PHYSICIAN’S SIGNATURE ……………………………………………

*OFFICIAL STAMP*

PHYSICIAN’S NAME ……………………………………………………