



**PAN AFRICAN POSTAL UNION
MEDICAL EXAMINATION REPORT FORM**

DATE:/...../.....

NAME/DR/MR/MRS/MISS:

DATE OF BIRTH : SEX :

FAMILY MEDICAL HISTORY:

PERSONAL MEDICAL HISTORY:

- (a) HEREDITARY OR CONGENITAL CONDITIONS
- (b) SERIOUS OR CHRONIC DISEASES
- (c) ACCIDENTS
- (d) SURGICAL OPERATON
- (e) HOSPITALIZATION
- (f) WEIGHT CHANGE IN PAST YEAR
- (g) SKIN INFECTIONS

PRESENT CONDITION:

(1) **GENERAL CONDITION**

HEIGHT WEIGHT SKIN

(2) **DIGESTIVE SYSTEM**

TEETH TONGUE
 ABDOMEN
 LIVER SPLEEN
 HERNIA RECTAL EXAMINATION.....

(3) **CIRCULATORY SYSTEM**

PULSE BLOOD PRESSURE
 AUSCULTATION
 APEX BEAT VESSELS

(4) **RESPIRATORY SYSTEMS**

NOSE THROAT

CHEST

AUSCULTATION.....

(5) **AUDITORY SYSTEM**

EARS

HEARING	DRUMS
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RIGHT

LEFT

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E-mail Address
Adresse E-mail
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- (6) VISION
 EYES
 ACUITY (CORRECTED) (UNCORRECTED)
 FIELDS COLOUR
- (7) GENITOURINARY SYSTEM
 GENITALIA KIDNEYS
 FOR WOMEN – L.M.P. PARA
 P.V. BREASTS
 PAP SMEAR IF POSSIBLE
- (8) LOCOMOTOR SYSTEM
 LIMBS
 GAIT DEFORMITY
- (9) NERVOUS SYSTEM
 TEMPERAMENT
 MENTAL STATUS
 CRANIAL NERVES
 SUPERFICIAL REFLEXES
- (10) 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)

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DATE/...../.....



OFFICIAL STAMP

PHYSICIAN'S SIGNATURE

PHYSICIAN'S NAME

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