



## MEDICAL EXAMINATION REPORT

LAST NAME <u>ABREGANA</u>		FIRST NAME <u>MIRICAR ROSS</u>		MIDDLE INITIAL <u>AMASA</u>	PRESENT MAILING ADDRESS <u>EL GUSTO DR. MABOLO, CEBU CITY</u>		
SEX <u>F</u>	AGE <u>25</u>	CIVIL STATUS <u>SINGLE</u>	ID NO.	OCCUPATION/POSITION <u>CUSTOMER SERVICE</u>	COMPANY <u>IPLOY STAFFING SOLUTIONS</u>	TELEPHONE NO. <u>09060376892</u>	

**I. MEDICAL HISTORY - Has applicant suffered from, or has been told that he had, any of the following conditions:**

- |  |                                       |    |                      |                                    |                         |                                   |                     |                                  |                     |                                   |                           |                                       |                            |                                 |                       |                                   |                           |                        |                                      |                         |  |     |    |                               |                                |                                 |                                      |   |                            |                               |                                  |   |
|--|---------------------------------------|----|----------------------|------------------------------------|-------------------------|-----------------------------------|---------------------|----------------------------------|---------------------|-----------------------------------|---------------------------|---------------------------------------|----------------------------|---------------------------------|-----------------------|-----------------------------------|---------------------------|------------------------|--------------------------------------|-------------------------|--|-----|----|-------------------------------|--------------------------------|---------------------------------|--------------------------------------|---|----------------------------|-------------------------------|----------------------------------|---|
| <table border="0"> <tr><td>Yes</td><td>No</td></tr> <tr><td>1. ( ) ( / ) Allergy</td><td>10. ( ) ( / ) Ear Trouble/Deafness</td></tr> <tr><td>2. ( ) ( / ) Amoebiasis</td><td>11. ( ) ( / ) Endocrine Disorders</td></tr> <tr><td>3. ( ) ( / ) Anemia</td><td>12. ( ) ( / ) Frequent Headaches</td></tr> <tr><td>4. ( ) ( / ) Asthma</td><td>13. ( ) ( / ) Head or Neck Injury</td></tr> <tr><td>5. ( ) ( / ) Cancer/Tumor</td><td>14. ( ) ( / ) Heart Diseases/Troubles</td></tr> <tr><td>6. ( ) ( / ) Chronic Cough</td><td>15. ( ) ( / ) Hernia (Ruptured)</td></tr> <tr><td>7. ( ) ( / ) Diabetes</td><td>16. ( ) ( / ) High Blood Pressure</td></tr> <tr><td>8. ( ) ( / ) Dysmenorrhea</td><td>17. ( ) ( / ) Insomnia</td></tr> <tr><td>9. ( ) ( / ) Fainting Spells/Seizure</td><td>18. ( ) ( / ) Hepatitis</td></tr> </table> | Yes                                   | No | 1. ( ) ( / ) Allergy | 10. ( ) ( / ) Ear Trouble/Deafness | 2. ( ) ( / ) Amoebiasis | 11. ( ) ( / ) Endocrine Disorders | 3. ( ) ( / ) Anemia | 12. ( ) ( / ) Frequent Headaches | 4. ( ) ( / ) Asthma | 13. ( ) ( / ) Head or Neck Injury | 5. ( ) ( / ) Cancer/Tumor | 14. ( ) ( / ) Heart Diseases/Troubles | 6. ( ) ( / ) Chronic Cough | 15. ( ) ( / ) Hernia (Ruptured) | 7. ( ) ( / ) Diabetes | 16. ( ) ( / ) High Blood Pressure | 8. ( ) ( / ) Dysmenorrhea | 17. ( ) ( / ) Insomnia | 9. ( ) ( / ) Fainting Spells/Seizure | 18. ( ) ( / ) Hepatitis | <table border="0"> <tr><td>Yes</td><td>No</td></tr> <tr><td>19. ( ) ( / ) Kidney Diseases</td><td>20. ( ) ( / ) Mental Disorders</td></tr> <tr><td>21. ( ) ( / ) Nervous Breakdown</td><td>22. ( ) ( / ) Nose or Throat Trouble</td></tr> <tr><td>23. ( ) ( / ) Peptic Ulcer/Stomach Pain</td><td>24. ( ) ( / ) Tuberculosis</td></tr> <tr><td>25. ( ) ( / ) Hospitalization</td><td>26. ( ) ( / ) Surgical Operation</td></tr> </table> | Yes | No | 19. ( ) ( / ) Kidney Diseases | 20. ( ) ( / ) Mental Disorders | 21. ( ) ( / ) Nervous Breakdown | 22. ( ) ( / ) Nose or Throat Trouble | 23. ( ) ( / ) Peptic Ulcer/Stomach Pain | 24. ( ) ( / ) Tuberculosis | 25. ( ) ( / ) Hospitalization | 26. ( ) ( / ) Surgical Operation | <p style="text-align: center;"><i>WMP 19/11/18</i></p> <p style="text-align: center;"><i>my Ceo P</i></p> |
| Yes  | No                                    |    |                      |                                    |                         |                                   |                     |                                  |                     |                                   |                           |                                       |                            |                                 |                       |                                   |                           |                        |                                      |                         |  |     |    |                               |                                |                                 |                                      |   |                            |                               |                                  |   |
| 1. ( ) ( / ) Allergy   | 10. ( ) ( / ) Ear Trouble/Deafness    |    |                      |                                    |                         |                                   |                     |                                  |                     |                                   |                           |                                       |                            |                                 |                       |                                   |                           |                        |                                      |                         |  |     |    |                               |                                |                                 |                                      |   |                            |                               |                                  |   |
| 2. ( ) ( / ) Amoebiasis  | 11. ( ) ( / ) Endocrine Disorders     |    |                      |                                    |                         |                                   |                     |                                  |                     |                                   |                           |                                       |                            |                                 |                       |                                   |                           |                        |                                      |                         |  |     |    |                               |                                |                                 |                                      |   |                            |                               |                                  |   |
| 3. ( ) ( / ) Anemia  | 12. ( ) ( / ) Frequent Headaches      |    |                      |                                    |                         |                                   |                     |                                  |                     |                                   |                           |                                       |                            |                                 |                       |                                   |                           |                        |                                      |                         |  |     |    |                               |                                |                                 |                                      |   |                            |                               |                                  |   |
| 4. ( ) ( / ) Asthma  | 13. ( ) ( / ) Head or Neck Injury     |    |                      |                                    |                         |                                   |                     |                                  |                     |                                   |                           |                                       |                            |                                 |                       |                                   |                           |                        |                                      |                         |  |     |    |                               |                                |                                 |                                      |   |                            |                               |                                  |   |
| 5. ( ) ( / ) Cancer/Tumor  | 14. ( ) ( / ) Heart Diseases/Troubles |    |                      |                                    |                         |                                   |                     |                                  |                     |                                   |                           |                                       |                            |                                 |                       |                                   |                           |                        |                                      |                         |  |     |    |                               |                                |                                 |                                      |   |                            |                               |                                  |   |
| 6. ( ) ( / ) Chronic Cough   | 15. ( ) ( / ) Hernia (Ruptured)       |    |                      |                                    |                         |                                   |                     |                                  |                     |                                   |                           |                                       |                            |                                 |                       |                                   |                           |                        |                                      |                         |  |     |    |                               |                                |                                 |                                      |   |                            |                               |                                  |   |
| 7. ( ) ( / ) Diabetes  | 16. ( ) ( / ) High Blood Pressure     |    |                      |                                    |                         |                                   |                     |                                  |                     |                                   |                           |                                       |                            |                                 |                       |                                   |                           |                        |                                      |                         |  |     |    |                               |                                |                                 |                                      |   |                            |                               |                                  |   |
| 8. ( ) ( / ) Dysmenorrhea  | 17. ( ) ( / ) Insomnia                |    |                      |                                    |                         |                                   |                     |                                  |                     |                                   |                           |                                       |                            |                                 |                       |                                   |                           |                        |                                      |                         |  |     |    |                               |                                |                                 |                                      |   |                            |                               |                                  |   |
| 9. ( ) ( / ) Fainting Spells/Seizure   | 18. ( ) ( / ) Hepatitis               |    |                      |                                    |                         |                                   |                     |                                  |                     |                                   |                           |                                       |                            |                                 |                       |                                   |                           |                        |                                      |                         |  |     |    |                               |                                |                                 |                                      |   |                            |                               |                                  |   |
| Yes  | No                                    |    |                      |                                    |                         |                                   |                     |                                  |                     |                                   |                           |                                       |                            |                                 |                       |                                   |                           |                        |                                      |                         |  |     |    |                               |                                |                                 |                                      |   |                            |                               |                                  |   |
| 19. ( ) ( / ) Kidney Diseases  | 20. ( ) ( / ) Mental Disorders        |    |                      |                                    |                         |                                   |                     |                                  |                     |                                   |                           |                                       |                            |                                 |                       |                                   |                           |                        |                                      |                         |  |     |    |                               |                                |                                 |                                      |   |                            |                               |                                  |   |
| 21. ( ) ( / ) Nervous Breakdown  | 22. ( ) ( / ) Nose or Throat Trouble  |    |                      |                                    |                         |                                   |                     |                                  |                     |                                   |                           |                                       |                            |                                 |                       |                                   |                           |                        |                                      |                         |  |     |    |                               |                                |                                 |                                      |   |                            |                               |                                  |   |
| 23. ( ) ( / ) Peptic Ulcer/Stomach Pain  | 24. ( ) ( / ) Tuberculosis            |    |                      |                                    |                         |                                   |                     |                                  |                     |                                   |                           |                                       |                            |                                 |                       |                                   |                           |                        |                                      |                         |  |     |    |                               |                                |                                 |                                      |   |                            |                               |                                  |   |
| 25. ( ) ( / ) Hospitalization  | 26. ( ) ( / ) Surgical Operation      |    |                      |                                    |                         |                                   |                     |                                  |                     |                                   |                           |                                       |                            |                                 |                       |                                   |                           |                        |                                      |                         |  |     |    |                               |                                |                                 |                                      |   |                            |                               |                                  |   |

**II. FAMILY HISTORY**

- |  |                     |    |                       |                     |                           |                     |  |     |    |                                  |  |
|--|---------------------|----|-----------------------|---------------------|---------------------------|---------------------|--|-----|----|----------------------------------|--|
| <table border="0"> <tr><td>Yes</td><td>No</td></tr> <tr><td>1. ( ) ( / ) Diabetes</td><td>3. ( ) ( / ) Cancer</td></tr> <tr><td>2. ( ) ( / ) Hypertension</td><td>4. ( ) ( / ) Asthma</td></tr> </table> | Yes                 | No | 1. ( ) ( / ) Diabetes | 3. ( ) ( / ) Cancer | 2. ( ) ( / ) Hypertension | 4. ( ) ( / ) Asthma | <table border="0"> <tr><td>Yes</td><td>No</td></tr> <tr><td>5. ( ) ( / ) Endocrine Disorders</td><td></td></tr> </table> | Yes | No | 5. ( ) ( / ) Endocrine Disorders |  |
| Yes  | No                  |    |                       |                     |                           |                     |  |     |    |                                  |  |
| 1. ( ) ( / ) Diabetes  | 3. ( ) ( / ) Cancer |    |                       |                     |                           |                     |  |     |    |                                  |  |
| 2. ( ) ( / ) Hypertension  | 4. ( ) ( / ) Asthma |    |                       |                     |                           |                     |  |     |    |                                  |  |
| Yes  | No                  |    |                       |                     |                           |                     |  |     |    |                                  |  |
| 5. ( ) ( / ) Endocrine Disorders   |                     |    |                       |                     |                           |                     |  |     |    |                                  |  |

**III. PHYSICAL EXAMINATION**

Height 154.5 cm. Weight 46.7 kg. BMI 19.6

Blood Pressure 110/70 mmHg. Pulse Rate 76 /min.

Description	Normal		Findings
	Yes	No	
Head, Neck, Scalp			
Eyes, External			
Ears			
Nose, Sinuses			
Mouth, Throat			
Neck, L.N. Thyroid			
Chest-Breast-Axilla			
Heart			

Description	Normal		Findings
	Yes	No	
Lungs			
Abdomen			
Back			
Anus-Rectum			
GUT System			
Inguinals, Genitals (Hernia)			
Reflexes			
Extremities			
Dental (Teeth)			

**IV. RADIOLOGICAL / LABORATORY EXAMINATIONS:**

- |   |  |
|---|--|
| <p><b>A. COMPLETE BLOOD COUNT</b><br/>                 ( ) Findings ( ) Normal</p> <p><b>B. URINALYSIS</b><br/>                 ( ) Findings ( ) Normal</p> <p><b>C. FECALYSIS</b><br/>                 ( ) Findings ( ) Normal</p> <p><b>D. SEROLOGICAL EXAMS</b><br/>                 HIV: ( ) Reactive ( ) Nonreactive<br/>                 VDRL: ( ) Reactive ( ) Nonreactive</p> <p><b>E. BLOOD TYPING</b> _____</p> <p><b>F. ECG 12 Leads</b> _____</p> <p><b>G. CHEST X-RAY #</b> <u>18-10394</u><br/>                 ( / ) PA ( ) Apicolordotic View<br/>                 ( / ) Normal<br/>                 ( ) Findings</p> | <p><b>H. HEPATITIS SCREENING</b><br/>                 HBsAg: ( ) Reactive ( ) Nonreactive<br/>                 Anti-HBs: ( ) Reactive ( ) Nonreactive<br/>                 Anti-HCV: ( ) Reactive ( ) Nonreactive<br/>                 Anti-HAV: ( ) Reactive ( ) Nonreactive</p> <p><b>I. DRUG TEST</b><br/>                 Methamphetamine ( ) Positive ( ) Negative<br/>                 Tetrahydrocannabinol ( ) Positive ( ) Negative</p> <p><b>J. OTHERS:</b><br/>                 _____<br/>                 _____</p> |
|---|--|

PHYSICALLY FIT

**RATING**

- \_\_\_\_\_ Class A = Physically fit for all types of work. No Physical defect noted.
- \_\_\_\_\_ Class B = Physically fit for all types of work. Has minor ailments / defect. Easily curable or offers no handicap to job applied.
- \_\_\_\_\_ Class C = Physically fit for less strenuous type of work. Has minor ailments / defect. Easily curable or offers no handicap to job applied.
- \_\_\_\_\_ Class D = Employment at risk with discretion of management.
- \_\_\_\_\_ Class E = Unfit for employment.
- \_\_\_\_\_ Pending A. For Further Evaluation \_\_\_\_\_ B. For Further Treatment \_\_\_\_\_

**REMARKS / RECOMMENDATIONS**

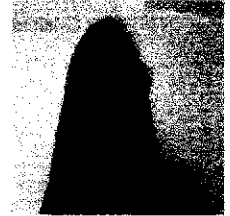


Name: Abregana, Miricar  
 Ross A. Age: 25

Sex: Female Date: 07/25/2018

Physician: X-ray #: 18-15394

Walk in



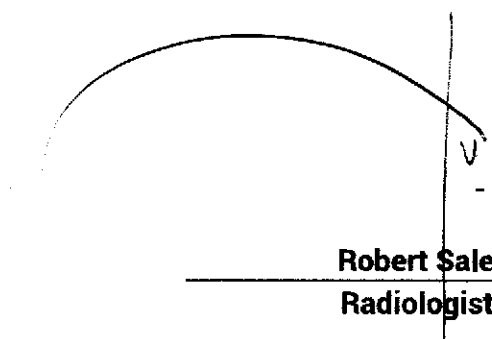
### XRAY REPORT

#### CHEST PA:

Both lung fields are clear. The trachea is in the midline. The heart is not enlarged. Both hemidiaphragms are sharp and distinct. The osseous thoracic cage showed no significant abnormality.

#### Impression:

NORMAL CHEST



Rad-Tech

Robert Sales, MD., FPCR  
Radiologist / Sonologist



Accredited by:



169 Sanciangko St. Cebu City 6000 Philippines

Tel No. (032) 416-4390 loc. 115 ★ Fax No. 255-6055 ★ Email: ra.catingub@glaboratories.com  
www.glaboratories.com

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ABREGANA ^ MIRICAR ROSS

18-15394/025Y/F

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W= 16478  
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