

MEDICAL EXAMINATION RECORD

Annual Physical Examination []

Pre-Employment []

Last Name MOZA First Name DIANNE DILL M.I. C Date 05/25/19
 Address BAUNTHWAK ST. STO. NIÑO, GUNZO Age 20 Civil Status SINGLE Sex FEMALE
 Place of Birth CEBU CITY Date of Birth 09/09/1998 Insurance Provider _____
 Occupation CALL CENTER Name of Company IPLOY STAFFING SOLUTIONS Tel. / Mobile no. 0939617279

PHYSICAL EXAMINATION

Temp.: 35.7 °C PR: 41 bpm RR: 16 bpm BP: 100/70 mmHg Ht: 156 cm Wt: 52 kgs.
 Visual Acuity: Right Eye: 20/20 Left Eye: 20/20 BMI: 21.3 Underweight: Overweight:
 (With/ Without eyeglasses) Normal Weight: Obese:

MEDICAL HISTORY

Past Medical History: (-) BA pres: cough for 3 dys.
 Family History: None
 Previous Hospitalization: Admission fever
 Menstrual History: 13 y.o. Parity: 6090 LMP: 4/29/2019 Contraceptive Use: None
menstrue - irregular 5 days - 1 week

Review of Systems	Normal	Findings	Review of Systems	Normal	Findings
Head & Scalp	/		Lungs	/	
Eyes & Ears	/		Heart	/	
Skin / Allergy	/		Abdomen	/	
Nose & Sinuses	/		Genitals	-	
Mouth / Teeth / Tongue	/		Extremities	/	
Neck / Nodes	/		Reflexes	/	
Chest / Breast	/		BPE	-	

Laboratory	Normal	Findings	Laboratory	Normal	Findings
Chest X-Ray	/		ECG		
CBC	/		Other Procedures:		
Urinalysis	/				
Fecalysis	/				
Drug Test	/				

I certify that I have examined and found the employee to be physically [] Fit [] Unfit for employment.

Classification:

- CLASS A Physically fit for all types of work
- CLASS B Physically fit for all types of work
Has minor ailment/ defect. Easily curable or offers no handicap to job applied.
[] Needs treatment/ correction
[] Treatment optional for: _____
- CLASS C Physically fit for less strenuous type of work. Has minor ailments/ defects.
Easily curable or offers no handicap to job applied.
[] Needs treatment/ correction
[] No treatment needed for: _____
- CLASS D Employment at the risk and discretion of the management
- CLASS E Unfit for employment
- PENDING For further evaluation of: _____

Remarks: _____
Dianne Patient's Signature 5/27/19 Date Examined _____ Medical Examiner _____, M.D.
 License No.: _____

