PRE-EMPLOYMENT / PERIODICAL MEDICAL EXAMINATION FORM

|  |  |
| --- | --- |
| **EMPLOYMENT’S**  |  Photo |
| Job Tittle: |  |
| Register No: |  |
| Address: |  |
| Telephone and Fax: |  |
| E-mail: |  |
|  I certify that the statements made by me in answer to questions below are, to the best of my knowledge, true, complete and correct. I realize that any incorrect statement or material omission in the medical information form or in any other document required by the Organization renders a staff member liable to termination or dismissal. Employee's Name and Surname                                                       SIGNATURE**-------------------------------------------------------------------------------------------------------------------------****EMPLOYEE’S**  |
| Name an Surname |  |
| Republic of Turkey Identity Number |  |
| Birth Place and Date |  |
| Gender |  |
| Educational level |  |
| Marital Status |  | Number of Children |  |
| Home Address |  |
| Phone Number |  |
| Job |  |
| His work (to be described in detail.) |  |
| Work section |  |
| Prior Employment (Start with most recent job) | Job Title | His work | Entry-Exit Date |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |
| **Biography** |  |
| Blood Group |  |
| Congenital / Chronic Diseases |  |
| Immunization |
| - Tetanus |  |
|  - Hepatitis |  |
| - Other |  |
| **Pedigree History(**Chronic Diseases**)** |
| Mother | Father | Sister/Brother | Children |
|  |  |  |  |
| **REVIEW OF SYMPTOMS** |
| 1. Do you have any of the following ? | No | Yes |
| - Cough |  |  |
| - Shortness of breath  |  |  |
| - Chest pain |  |  |
| - Palpitation |  |  |
| - Backache |  |  |
| - Diarrhea or Constipation |  |  |
| - Joint Pain |  |  |
| 2. Do you have any of the following ? | No | Yes |
| - Heart disease |  |  |
| - Diabetes |  |  |
| - Kidney disease |  |  |
| - Jaundice |  |  |
| - Gastric or duodenal ulcers |  |  |
| - Hearing lossHearing loss |  |  |
| - Defect of vision |  |  |
| - Nervous system diseases |  |  |
| - Skin disease |  |  |
| - Food poisoning |  |  |
| 3. Did you stay in the hospital? | No |  | If yes, diagnosis ? |  |
| 4. Have you had surgery? | No |  | If yes, why ? |  |
| 5. Have you had an accident at work? | No |  | If yes, what happened ? |  |
| 6. Investigations relating to occupational diseases and suspected Have you been examined? | No |  | If yes, result ? |  |
| 7. Did you receive disability? | No |  | If yes, what is it and rate ? |  |
| 8. Are you getting any treatment at the moment? | No |  | If yes, what ? |  |
| 9. Do you smoke? | No |  |  |
|  | Leaving  |  | .........months/years ago | ............. month/year drank | ........... units/day drank |
|  | Yes |  | ..........years | .............. units/day |
| 10. Do you drink alcohol? | No |  |  |
|  | Leaving  |  | ..............year ago | ..............year drank | ................ often drank |
|  | Yes |  | ..........years | ..............often |
| **PHYSICAL EXAMINATION RESULTS** |
| a) Sensory organs |  |
|  - Eye |  |
|  - Ear-Nose-Throat |  |
|  - Skin |  |
| b) Cardiovascular system examination |  |
| c) Respiratory examination |  |
| d) Examination of the digestive system |  |
| e) Urogenital system examination |  |
| f) Musculoskeletal examination |  |
| g) Neurological examination |  |
| Ğ) Psychiatric examination |  |
| h) Other |  |
|  -TA : / mm-Hg |
|  -Nb : / min. |
|  -Size: Kilo: Body Mass Index: |
| **LABORATORY FINDINGS** |
| a) Biological assays |  |
| - Blood |  |
| - Pee |  |
| b) Radiological analysis |  |
| c) Physiological analysis |  |
| - Audiometry |  |
| - SFT |  |
| d) Psychological tests |  |
| e) Other |  |

**YOUR DOCTOR’S DETAILS \* :**

**1- …………………………………………………………………………………………………………..…………………….… suitable for physically and mentally working in the business.**

**2- ……………………………………………………………………………………………..…………………… provided that is suitable for work.**

*(\* Working in the physical examination results or night shift body health and integrity of the work and can not work in working conditions appropriate complementary tools, equipment, etc ... for employees when there will be stated the opinion that it is convenient to work with this requirement.)*

 **……...... / ............. / 20.............**

**SIGNATURE**

**Name and Surname :**

**Diploma Date and No:**

**Diploma Registration Date and Number:**

**Commercial Practice Document Date and No:**