Qatargas Medical Department



MEDICAL EXAMINATION FORM (Qatargas Employees and Applicants)

Section A. To be completed by the employee. Any information and reports given will be treated with strict confidence by the staff of Qatargas Medical Department.												
☐ PRE EMPLOYMENT	☐ PEF	RIODIC	□ EXT	ENSIO	N	□ PF	REPL	ACEMENT	□ EXIT		SCHOL	ARSHIP
1.PHOTO (Pre-Employment only) 2. Information Sticker (others)		Family Name:							First Name:			
		Staff No:				Nationality:			QID No (Passport No. for Pre-employment):			
		Shift Group: <i>(Please tick)</i> ☐ A ☐ B ☐ C ☐ D ☐ General ☐ Others										
		Work L			Department:							
	Position: Contact Number:											
		Present Address:										
Vaccination History:			YES	NO						YES	N	0
Hepatitis A					Chicken Pox (Offshore only)* □							
Hepatitis B	· · · · · · · · · · · · · · · · · · ·				Covid 19 (Brand Name) *							
Tetanus										any)		
Measles (Offshore only)*										*	Certificates	required
Medical History: (If yes, p	lease tick (appropria	te box)									
					Mu	sculo-	Skele	etal Problems	or Injuries			
Blood Disorder & Immune System e.g., Allergies Ear/Sinuses Illnesses					Musculo-Skeletal Problems or Injuries □ □ Heart Disease/Heart Attack/Angina □ □							
Epilepsy						h Bloo	-		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
	Asthma Bro	nchitis						tus (Oral/Insuli	n)			
Chest Disease: Tuberculosis, Asthma, Bronchitis Peptic Ulcer/Rectal Bleeding/Bowel Disease												
	_	.i Discusc			, , , , , , , , , , , , , , , , , , , ,							
Hepatitis/Jaundice/Typhoid Recurrent Abdominal Pain						-			50.5			
								mitted Disea	SE 5			
Kidney or Bladder Trouble		, , , , , , , , , , , , , , , , , , , ,										
Mental Illness				5								
Recurrent Headache				Others if any: \Box								
Cancer Malignancy]	
Is there any family histor	y of :				-							
Diabetes					Asthma/Allergies □]	
High Blood Pressure	High Blood Pressure				Heart Diseases □						1	
Cancer Malignancy	Cancer Malignancy				Epi	lepsy/l	Fits]
Others:												
History of hospitalization in the last 1 year?					YES		NO	If Yes, w	hy and for hov	v long?		
Are you regularly taking any prescribed medications?					YES		NO	If yes, gi	ve details:			
How many days per week	do you e	ngage in	moderate	to stre	nuou	s exerc	cise?					
On average how many mi at this level	inutes do	you exer	cise \square	0 min	ıs		1-1	49 min/weel	⟨□ 150	or mor	e mins pe	erweek
How stressful do you feel	lyour life i	is?On a s	cale of 1-1	L0 wh	ere 10) is the	high	est.				
How many hours of uninterrupted sleep do you get per day ?												
Do you smoke?					YES		NO	If yes, w How lon	hat type? g?	How	many?	
Do you drink alcohol?					YES		NO	If yes, w Since wh	hat type? ien?			
How many times in the past year you had, 5 drinks a day (for males) / 4 drinks a day (for females) or more?												
Are you currently taking any illegal substance?					YES		NO	If yes, w How lon	hat type? g?	Freq	uency?	
Have you had any illness, injury or hospitalization that has made you absent from work in the last two years?					YES		NO		ve details:	,	•	
Do you feel fit and health	П	YES	П	NO	If NO. w	hv?						

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Classification: Internal

What are the sources of your fears? e.g., heights, confined space, flying, sea water, and others													
What stresses you?													
DECLARATION:													
								of any other physic communicated by t					
affect my work. I also agree that the medical results and information herein may be communicated by the Medical Department to other departments if required.													
I accept that Qatargas will not be liable for any pre-existing medical condition in myself or my dependents unless explicitly stated in writing.													
Date:	Date: Signature:												
Section B. To be completed by the Examining Doctor. Additional tests may be requested when necessary.													
I. PHYSICAL EXAMINATION							II. LABO	RATORY REPORTS					
Organ and S	ystem		Normal	Abnormal	Rema	rks	Laboratory Report	s	Normal	Abnormal	Remarks		
Eyes							Fasting Blood G	Glucose					
Ear, Nose	, Throat						Complete Bloo	d Count					
Oral cavit	У						Blood platelet	Count					
Chest								Test: (SGPT, SGOT,					
Cardiovas	cular syste	m					Bilirubin, Y GT)						
Abdomina	al						Renal Function	•					
Hernia or							Creatinine, Uric Ac	cid)					
	Anus and rectum (if necessary)					Total Cholesterol, HDL/LDL							
Genito-urinary (if necessary)						Urinalysis	/						
Extremities							Electrocardiog	ram (ECG)					
Musculo-skeletal				<u> </u>		Spirometry							
Skin Varisasa vains				1		Audiometry Chest X-ray (over	arcaac) (" · · · · · ·						
Varicose veins							Chest X-ray (ove						
CNS						(overseas) std (vDR							
Section C. Biometrics (To be completed by the						Others test if ne	eeded:						
		Waist					•	ant noar	Color	Dland Cva			
Height (cm)	Weight (kg)	(cm)	ВМІ	PR	BP	Visio	n: dista R	ant near LRL	Color Blood Group: Vision Type:				
						Unco Corre	rrected			Rh:(ve)			
Fitness (Conclusio	n:			<u>l</u>	Corre	cteu	l I					
☐ FIT to work ☐ Fit with conditions ☐ For Further Review ☐ UNFIT to work													
Required Surveillance:													
☐ None ☐ Hypertension ☐ Diabetes													
☐ Hearing Conservation☐ Respiratory Protection☐ MSD☐ Others:													
Certified by:				Signature/Stamp:				Date:					
Dr													
CONFIDENTIAL													
			<i>J</i> 1'	v F		U	L IV		AL				