PROFORMA FOR MEDICAL EXAMINATION

FOR ENGAGEMENT OF TENURE BASED CPW IN ORDNANCE FACTORY ITARSI

Candidate's personal declaration:

(To be filled in by the candidate with the assistance of hospital staff assigned for the purpose)

Please answer all questions honestly, accurately and completely. If you do not understand any question, please seek clarification from the examining medical officer or staff designated to assist you. The information provided regarding your medical history and health habits will be used to make a careful medical assessment of whether you can safely and efficiently perform the essential functions of the job for which you are a candidate and will not necessarily disqualify you from employment. Detailed medical information will be treated confidentially.

Please note that furnishing of false information or suppression of any factual information would be a disqualification for the job and will render the candidate unfit for any employment under the Government. If the fact that false information has been furnished or that there has been suppression of any factual information comes to notice at any time during the service of a person, the candidate's services would be liable to be terminated.

Candidate's personal information :

Paste photo of the candidate here To be attested by the MO carrying out the medical examination.

1. Post for which the candidate has been offered appointment : **Tenure Based CPW**

2. Name in full (In block letters) (last, first, middle) :

   ____

3. Date of birth : ____________________

4. Age : _______ yrs (In completed years)

5. Sex : Male/ Female

6. Marital Status : Married/ Unmarried.

Health questionnaire :

Do you now have or have ever had any of the following conditions?

(Strike out whichever is not applicable)

1.	High blood pressure	Yes	No
2.	Heart/blood vessel disease	Yes	No
3.	Irregular heart rhythm.	Yes	No
4.	Abnormal ECG	Yes	No
5.	Varicose veins	Yes	No
6.	Chest pain	Yes	No
7.	Breathlessness	Yes	No
8.	Leg swelling	Yes	No
9.	Leg pain on walking	Yes	No
10.	Asthma	Yes	No
11.	Tuberculosis	Yes	No
12.	Cough > 1 month	Yes	No
13.	Coughing up of blood	Yes	No
14.	Blood disorder/ anaemia	Yes	No
15.	Abnormal blood clotting	Yes	No
16.	High or low blood cell counts	Yes	No
17.	Enlarged spleen	Yes	No
18.	Diabetes	Yes	No
19.	Thyroid or other endocrine problem	Yes	No
20.	Kidney problem	Yes	No
21.	Urine problems	Yes	No
22.	Skin problem	Yes	No
23.	Infectious/ contagious diseases	Yes	No
24.	Genital problems	Yes	No
25.	Pregnancy	Yes	No
26.	Frequent or persistent sleep problems	Yes	No
27.	Epilepsy/ fits	Yes	No

28.	Giddiness/ fainting	Yes	No
29.	Loss of consciousness	Yes	No
30.	Severe/ frequent headaches	Yes	No
31.	Speech disorder	Yes	No
32.	Balance problem	Yes	No
33.	Stroke, aneurysm or bleeding in head	Yes	No
34.	Paralysis or muscle abnormality	Yes	No
35.	Any other neurological abnormality	Yes	No
36.	Mental illness	Yes	No
37.	Depression	Yes	No
38.	Attempted suicide	Yes	No
39.	Eye/ vision problem	Yes	No
40.	Need for corrective lenses?	Yes	No
41.	Deficiency of colour vision	Yes	No
42.	Oral health problems	Yes	No
43.	Digestive problem	Yes	No
44.	Difficulty in swallowing	Yes	No
45.	Blood in motion	Yes	No
46.	Frequent or persistent stomach pain	Yes	No
47.	Frequent or persistent vomiting	Yes	No
48.	Vomiting of blood	Yes	No
49.	Jaundice	Yes	No
50.	Hernia	Yes	No
51.	Piles	Yes	No
52.	Motion problems	Yes	No
53.	Liver,pancreas or gall bladder disease	Yes	No

54.	Ear / nose/ throat/ sinus problems	Yes	No
55.	Hearing deficiency	Yes	No
56.	Hoarseness of voice	Yes	No
57.	Joint problems/ Restricted mobility	Yes	No
58.	Back problems/ pain	Yes	No
59.	Amputation	Yes	No
60.	Fractures/ dislocations	Yes	No
61.	Any pins, plates or screws in legs or feet?	Yes	No
62.	AIDS, HIV infection or hepatitis	Yes	No
63.	Significant injuries	Yes	No

64.	Loss of weight > 5kg in last 6 months	Yes	No
65.	Medical treatment in past 12 months	Yes	No
66.	CT scan, MRI or other special tests	Yes	No
67.	Loss/ excess of appetite > 1 month in last 6 month	Yes	No
68.	Fever last one month	Yes	No
69.	Frequent or persistent itching	Yes	No
70.	Organ transplant	Yes	No
71.	Cancer or tumour	Yes	No

72.	Have you ever had any operation?	Yes	No
73.	Have you ever been hospitalized?	Yes	No
74.	Are you aware that you have any medical problems, diseases or illnesses?	Yes	No
75.	Are you allergic to any drug, food or other substances?	Yes	No
76.	Any health problem, which requires visits to doctor, or for which you take regular drugs?	Yes	No

If any of the above questions were answered “yes”, please give details by referencing item number. Provide information regarding diagnosis and treatment, including dates of treatment. Please use additional sheet (s), if necessary.

Are you taking any drugs?	Yes	No

If yes, please list the medications taken and the purpose(s) and dosage(s)

For Female candidates only :

(Strike out whichever is not applicable)

Menstrual History

Age at which first menses occurred : yrs

Duration of menstrual period : days.

Quantity : Normal/ clots/ profuse / scanty

Pain during menses : YES/NO

Menstrual cycles: Regular/ Irregular

Duration of menstrual cycle : days

Last menstrual period began on :

Obstetric History

Number of pregnancies :

Live births :

- Normal delivery :
- Caesarean :
- Forceps :

Still births :

Abortions :

Occupational history :

(Strike out whichever is not applicable)

77.	Have you ever been exposed to fumes, dust, chemicals, asbestos, loud noise or radiation at work or elsewhere?	Yes	No
78.	Have you ever received worker's disability/ compensation?	Yes	No
79.	Have you been absent from work for medical reasons in the past five years?	Yes	No
80.	Have you ever required light or restricted duty?	Yes	No
81.	Have you ever had any occupational injury	Yes	No.

If any of the above questions were answered " yes", please give details by referencing item number. Please use additional sheet (s), if necessary.

Do you use : *(Strike out whichever is not applicable)*

	NOW		In past		Details
Cigarettes	Yes	No	Yes	No	
Tobacco					
Alcohol					
Drug					

Family medical history :

Have your father, mother, any brother or sister had or has the following condition ?

(Mark Yes/ No)

Condition	Yes	No
Asthma	Yes	No
Allergic disease	Yes	No
Epilepsy	Yes	No
High Blood Pressure	Yes	No
Diabetes	Yes	No
Heart disease	Yes	No
Cancer	Yes	No
Stroke	Yes	No
Tuberculosis	Yes	No
Any other chronic or serious disease	Yes	No

If any " yes" answer, please give details by referencing item number
If father, mother, any brother or sister is not alive, their age and cause of death

Immunisation status :

Tetanus prophylaxis status :

☐ Total ≥ 3 injections & last < 10 yrs

☐ Total ≥ 3 injections & last > 10 yrs

☐ Total < injections

Others : (**e.g.hepatitis B for health workers**)

Past medical examinations :

1. Have you been examined by a Medical Board before? Yes/ No

2. If answer to the above is **YES,** please state

a) What Service/ Services you were examined for?

b) Who was the examining authority?

c) When and where was the Medical Board held?

d) Results of the Medical Board's Examination, if communicated to you or if known.

I hereby certify that all the above answers are, to the best of my knowledge and belief, true and correct.

Candidate's Signature

Signed in my presence

(Signature of Medical Officer)

(Name & designation (seal)

Health advice given :

Additional history recorded by medical officer :

Physical Examination :

After reviewing the medical history provided by the candidate, conduct a comprehensive medical examination of All systems necessary to determine the candidate's fitness for the post. The examination should include, but not be limited to, the areas listed below. If the candidate has conditions relevant to fitness which are not listed below the Medical officer is responsible for documenting all such conditions.

Identification Marks:

1. ____________________________________

2. ____________________________________

Sight :

	Visual acuity			
	Unaided		**Aided**	
	Right eye	Left eye	Right eye	Left eye
Distant				
Near				

(Tick yes or no)

	Visual fields	
	Normal	Defective
Right eye	☐	☐
Lefe eye	☐	☐

Colour vision :

☐ Normal ☐ Doubtful ☐ Defective

Hearing :

Whisper test (in metres) :

Right ear: _________ Left ear : _________

General examination:

Height :___________(cm)

Weight :_________ (kg)

BMI: ___________(KG/M^2)

Pulse rate: ______/minute, Regular/Irregular

Blood pressure (in mm Hg):

*Systolic:*________ *Diastolic:* _______

Systemic examination :

(Tick yes or no)

		Normal	**Abnormal**
1.	General appearance	☐	☐
2.	Pallor	☐	☐
3.	Oedema	☐	☐
4.	Jaundice	☐	☐
5.	Clubbing	☐	☐
6.	Cyanosis	☐	☐
7.	JVP	☐	☐
8.	Speech	☐	☐
9.	Mannerisms	☐	☐
10.	Attention	☐	☐
11.	Mood	☐	☐
12.	Head	☐	☐
13.	Eyes(General)	☐	☐
14.	Mouth/teeth	☐	☐
15.	Ears(general)	☐	☐
16.	Sinuses, nose, throat	☐	☐
17.	Thyroid	☐	☐
18.	Lymph nodes	☐	☐
19.	Lungs and chest	☐	☐

20.	Heart	☐	☐
21.	Abdomen and viscera	☐	☐
22.	G-U system	☐	☐
23.	Hernia	☐	☐
24.	Hydrocele	☐	☐
25.	Anus (not PR), piles	☐	☐
26.	Varicose veins	☐	☐
27.	Upper & lower limbs	☐	☐
28.	Spine	☐	☐
29.	Neurologic	☐	☐
30.	Skin	☐	☐

(Breast, PR, PV examinations will be carried out only if specifically indicated).

Details of abnormality:

Investigations:
Copies of all investigation reports, X-ray plates etc should be attached to this form as part of the record.

Blood Group : ☐ ☐

(Tick the appropriate box)

Investigations		Result	Normal	Abnormal
Hb			☐	☐
Blood sugar			☐	☐
Urine Albumin			☐	☐
Urine Sugar			☐	☐
CXR –PA			☐	☐
ECG			☐	☐
PEFR L/min	Candidate		☐	☐
	Predicted			

Other investigation (s) and result(s) :

Investigations	Result	Normal	Abnormal
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐

Describe abnormality if any :

Specialist Opinion (s) :
(Enclose the opinions)

Summary of significant findings:

Summarise abnormal medical history, physical examination findings, abnormal laboratory test results and any other relevant information obtained during your evaluation. Please document sufficient information so that your decision-making process is clear to any reviewer in the event that the candidate appeals an adverse fitness determination. Additional pages may be attached to this form.

Opinion:

☐ Fit

Description of disability/ required aids if any:

☐ Unfit

☐ Temporarily unfit for _______days/ weeks/ months.

Advice (if temporarily unfit):
(Specialist opinion/
Investigation/
Treatment, if any).

Signature of the **M.O.** **:**

Name of **MO** :

Designation :

Date :

Remedical Examination:

Date :

Opinion :

☐ Fit

Description of disability/ required aids if any :

☐ Unfit

Signature of the **M.O :**

Name of **MO** **:**

Designation :

Date :

Ref:- The requisition for medical examination No……………… dated …………..

The photo of the candidate to be pasted and attested by the MO carrying out the medical examination

Name of the post _______________________________

Name of the candidate :___________________________

Personal identification marks of the candidate :

1.____
2.____

☐ Initial examination
☐ Re-examination (refer out previous report dated ____________)

Report :

I hereby certify that I have evaluated the above candidate for medical fitness for engagement in Ordnance Factory, Itarsi on the above post on the basis of the information provided regarding working conditions and the requirements of physical abilities for the post , candidate's personal declaration, my clinical examination and investigation results and in accordance with standing instructions of the then Ordnance Factory Board. On the basis of above evaluation, my opinion regarding the medical fitness of the candidate for the above post is:

☐ Fit

Description of restrictions/required aids, if any:

☐ Unfit

☐ Temporarily unfit for a period of ____________

Date :

Signature of MO:
Name of MO:
Designation of MO:

I acknowledge that I have been advised of the content of the medical examination form.
I consent to the release of medical information under description of restrictions /aids required about me given above.

Signature of the Candidate: ____
(To be signed in presence of examination medical officer)