Non 24 hours

KPP-MER-1

24 hours

1. PP TAMAN DAHLIA
2. PP KOTA TINGGI
3. PP KULAI
4. PP MASAI
5. PP TAMAN ISTIMEWA PANDAN
6. PP TAMAN UNIVERSITI
7. PP SIMPANG RENGGAM
8. PP PONTIAN
9. PP SENAI
10. PP TAMAN SRI PULAI
11. PP TAMAN KOTA MASAI, BETIK
12. PP BANDAR BARU UDA
13. PP BANDAR PENAWAR
14. PP TAMAN RINTING
15. PP PUTERIWANGSA

Non 24 hours

1. PP TAMAN JOHOR JAYA
2. PP PASIR GUDANG
3. PP SEDILI
4. PP KLEDANG
5. PP PARIT BETAK
6. PP KG. PASIR, TAMPOI
7. PP TMN UNGKU TUN AMINAH
8. PP FELDA TENGGAROH 2
9. PP GELANG PATAH, JOHOR
10. PP DESA TEBRAU
11. PP TAMAN SRI PUTERI
12. PP KLANG
13. PP TAMAN DAYA
14. PP TAMAN PERLING
15. PP KOLAM AYER
16. PP TAMAN SERI ALAM
17. PP JLN TEMBIKAI, KOTA MASAI
18. PP SDE (IN-HOUSE CLINIC)
19. PP TMN SRI BAHAGIA
20. PP MMHE (IN-HOUSE CLINIC)

MEDICAL EXAMINATION REPORT

POLIKLINIK PENAWAR

Name :

IC No. (New) :

Sex : ☐ **Male** ☐ **Female**

Age : **Years Old**

Company :

Emp. No :

Department :

Date :

Patient's Name :

IC No :

Part I : Medical History

(To be completed by attending Physician)

		Yes	No	
1.	HIV / Aids	☐	☐	____________
2.	Tuberculosis	☐	☐	____________
3.	Malaria	☐	☐	____________
4.	Leprosy	☐	☐	____________
5.	Sexually Transmitted Diseases	☐	☐	____________
6.	Bronchial Asthma	☐	☐	____________
7.	Heart Disease	☐	☐	____________
8.	Hypertension	☐	☐	____________
9.	Diabetes Mellitus	☐	☐	____________
10.	Peptic Ulcer	☐	☐	____________
11.	Kidney Disease	☐	☐	____________
12.	Cancer	☐	☐	____________
13.	Epilepsy	☐	☐	____________
14.	Psychiatric Illness	☐	☐	____________
15.	Hearing Problem	☐	☐	____________
16.	Hepatitis	☐	☐	____________
17.	Allergy	☐	☐	____________
18.	Family Medical History	☐	☐	____________
19.	Smoker	☐	☐	About ☐ Stick Per day
20.	Others			

____

____

____

____

____

Patient's Signature

Date

Patient's Name :

IC No :

Part II : Physical Examination

(To be completed by examining doctor / physician)

SECTION A : GENERAL PHYSICAL EXAMINATION

1. Height : __________ cm 2. Weight : __________ kg 3. Pulse : _________ / min

BMI : ____________

4. Blood Pressure : Systolic : ________________ mm Hg Diastolic : ____________ Mm Hg

		Present	**Absent**	
5.	Chronic Skin Rash			
6.	Anaesthetic Skin Patch			
7.	Deformities Of Limbs			
8.	Anaemia			
9.	Jaujdice			
10.	Vision Test :	**Right**	**Left**	
	Unaided			
	Aided			
11.	Hearing Impairment			
12.	Colour Blindness			

SECTION B : SYSTEM EXAMINATION

		Normal	**Abnormal**	
1.	Cardiovascular System			
	1.1 Heart Size			
	1.2 Heart Sounds			
	1.3 Other Findings			

____

____

Patient's Name : ______________________________

IC No : ______________________________

2. Respiratory System

	Normal	Abnormal	
2.1 "Breath Sounds"	☐	☐	____________

2.2 Other Findings

____

____

3. Gastrointestinal

	Normal	Abnormal	
3.1 Liver	☐	☐	____________
3.2 Spleen	☐	☐	____________
3.3 Kidney	☐	☐	____________

3.4 Is There Any Abnormal Swelling? Yes / No Indicate if 'Yes'

____

____

3.5 Rectal Examination	☐	☐	____________
	☐	☐	____________

4. Nervous System And Mental Status

	Normal	Abnormal	
4.1 General Mental Status	☐	☐	____________
4.2 Speech	☐	☐	____________
4.3 Cognitive Function	☐	☐	____________
4.4 Size Of Peripheral Nerves	☐	☐	____________
4.5 Motor Power	☐	☐	____________
4.6 Sensory	☐	☐	____________
4.7 Reflexes	☐	☐	____________

5. Examination of The Genitourinary System

	Yes	No	
5.1 Discharge	☐	☐	____________
5.2 Sores / Ulcers	☐	☐	

____

____

Patient's Name : ____________________

IC No : ____________________

Part III : Laboratory Results, X-Ray Findings & Other Investigation

1. Urine Examination

   1.1 Urine (UFEME)

   Colour : ______________ Specific Gravity : ______________ pH : __________

	Negative	Positive
Sugar (Glucose)	☐	☐
Protein (Albumin)	☐	☐
Ketone	☐	☐
Urobilinogen	☐	☐
Leucocyte	☐	☐
Blood	☐	☐
Nitrite	☐	☐

1.2 Urine Opiates / Morphine	Positive	Negative	Not Done
1.3 Urine Cannabis	Positive	Negative	Not Done
1.4 Urine Pregnancy	Positive	Negative	Not Done

Kindly find details result as per laboratory report attached.

2. Chest X- Ray Not Done Done Date : ______________

   RN : ______________

	Normal	Abnormal
Heart	☐	☐
Lungs	☐	☐
Thorax	☐	☐

3. Other Tests / Investigation

   3.1 ______________________________

   3.2 ______________________________

   3.3 ______________________________

   3.4 ______________________________

   3.5 ______________________________

Patient's Name : ______________________________

IC No : ______________________________

Part IV : Certification By Physician / Doctor

1. CONCLUSION

   Comment :

From the medical history given, clinical examination, I am of the opinion that the above person is medically | FIT | UNFIT | for the occupation specified.

Signature Of Physician / Doctor

Date

Name And Qualification Of Physician / Doctor

Address Of The Physician / Doctor

Patient's Name :

IC No :