قطر للطاقة QatarEnergy	**OCCUPATIONAL HEALTH OVERSEAS PRE-EMPLOYMENT MEDICAL EXAMINATION FORM**	**REF.NO:**
		DATE:

Guidance notes for applicants and overseas medical center conducting the examination

- The purpose of this medical assessment is to identify physical and psychological problems which may affect the ability of the candidate to carry out the proposed employment in a safe and effective manner.
- To advise the candidate and the company if there are medical reasons why the duties of the position may not be suitable for the candidate.
- To identify those adjustments to employment that may be required to enable the employee to perform the job to the standard required.
- To record a baseline health profile for statutory health surveillance in order to measure and detect any health changes during employment.
- To ensure that expatriate worker is free from any infectious disease, in order to meet the requirements, set by - GCC rules and regulations of expatriate medical examination, Ministry of Interior ,Ministry of Labour, Ministry of Public Health - State of Qatar and QatarEnergy Fitness to work standards.

PART I – MEDICAL QUESTIONNAIRE (TO BE COMPLETED BY THE APPLICANT)

1. PERSONAL DETAILS

Full Name			
Gender	Male Female	Date Of Birth	
Nationality		Religion	
Marital Status		If Ex Employee previous staff no.	
Mailing Address			
Phone No.		Mobile No.	
Email			

2. FAMILY HEALTH STATUS

Relation	Age	State Of Health	If Dead, Cause Of Death	Age At Death
Father				
Mother				
Brother				
Sister				
Spouse				

3. ANY FAMILY HISTORY OF *(√as appropriate)*

	Diabetes		Asthma		Stroke
	High Blood Pressure		Epilepsy		Any Mental Illness
	Heart Disease		Tuberculosis		Any Cancer

4. VACCINATION RECORD *(√as appropriate)*

Have you ever been vaccinated for any of the following? If Yes please mention approximate date

	Yes	No	Date		Yes	No	Date
BCG				Polio			
Tetanus				Seasonal Influenza			
Hepatitis A				Varicella			
Hepatitis B				Meningococcal			
Pneumococcal				Yellow Fever			
Covid-19			Dates				

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5. OCCUPATIONAL HEALTH HISTORY

Any history of significant hazard exposure *(√as appropriate)*					
	Working at heights		Benzene		Manual handling
	Operating heavy equipment		H_2S		Biological risk
	Operate heavy vehicle		Pesticide Use		Radiation exposure
	Vibration/Motion		Lead		Dust
	Noise		Mercury		Nickel
	Chemical exposure		Cadmium		Organophosphate

Nature of last three jobs	**Dates**

Questions*(√or X as appropriate)*		**If Yes** *(Please give details below)*
Have you had any periods of continuous illness of two weeks or more during the last 5 years?		
Have you lost any time from work in the last 12 months due to illness or injury?		
Have you been admitted in hospital during the last 5 years?		
Have you ever made a claim for occupational injury or illness?		
Have you ever been considered medically unfit for any previous employment?		
Have you ever had to change jobs or works assignments because of a health problem or injury?		
Has any abnormality ever been detected in your chest x-ray?		
Do you have any special needs which you consider would impact on the job for which you are applying?		
Are you registered with government body for special needs?		
Are you aware of any health problems associated with your current/past job(s)?		
Did you ever consider psychiatric help, attended counseling sessions, had thoughts of self-harm?		
Have you ever been absent from work due to any psychological problem?		

6. LIFESTYLE HABITS *(√as appropriate)*

Are you a current smoker? Yes No If yes average cigarettes per day
If not a current smoker, have you ever smoked? Yes No If yes (how long did you smoke?) Yrs
Do you drink alcohol? Yes No If yes average amount per week?
Are you involved in any sporting activities? Yes No If yes (mention below type and frequency)
Do you use any recreational drugs? Yes No. If yes provide details below
If no, have you ever used any recreational drugs? Yes No. If yes provide details below

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7. MEDICAL HISTORY

Please complete the following checklist indicating if you have ever had the condition listed. For those checked "Yes," indicate whether the condition is current or in the past and give details regarding onset date, diagnosis, list all medications used and any current limitation. (√ As appropriate)

How would you rate your physical fitness? Poor Fair Good Excellent *(Tick only one)*

Conditions	Yes	No	Current	Past	Details
Any Vision Problem					
Color Vision Defect					
Any Ear Infection					
Hay Fever, Sinusitis, Severe Headaches					
Any Hearing Problem					
Tuberculosis					
Bronchitis / Emphysema					
Pneumonia / Pleurisy					
Asthma/ Breathlessness					
Any Blood Vessel Disorders / Varicose Vein					
Any Chest Disease/Pain					
Any Heart Disease					
Any Heart Surgery (Bypass, Angioplasty)					
Abnormal ECG Findings					
High blood pressure					
High cholesterol levels					
Weight problem					
Diabetes or Impaired fasting blood sugar					
Any Bleeding Disorders, Thrombosis, Anemia					
Any Joint Pain or Injury					
Broken Bones, Fractures or Dislocations					
Back Complaint / Back Injury /Disc Problem					
Muscle, Tendon or Ligament Problems					
Gout / Arthritis					
Hernia / Any Anal Problem/ Hemorrhoids					
Stomach or Duodenal Ulcers					
Any Abdominal Problem					
Hepatitis / Other Liver Problems					
Thyroid / Other Gland Problems					
Any Gallbladder Problems					
Any urinary problem / Kidney Disease					
Any Breast Problem					
Any Gynecological / Obstetric Problem					
Any Skin Problem Eczema, Dermatitis					
Allergy To Any Medicine, Food, Chemicals					

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Head Injury					
Epilepsy, Fainting, Fits, Blackouts					
Migraine / Vertigo					
Any Psychiatric Problems, Depression					
Anxiety / Irrational Fear					
Persistent Stress					
Mood Swing / Flight of Ideas					
Intolerable Sleep Problems					
Any memory loss					
Frequent bizarre experience					
Any Neurological Problem					
Any Major Surgery					
Any Tropical Disease e.g. Malaria					
Any Vehicle Accident Related Injury					
Any Regular Medication					
Any Tumor or Cancer					
Any Addiction e.g. Alcohol, Drugs					

8. DECLARATION *Please read the below statements and sign*

I hereby declare that:

- I understand that the information I provide will be retained on my employee file and that QatarEnergy reserves the right to access and use the information, in the event of an accident, injury, sickness or claim for workers' compensation or for any other reasonable purposes, if so, required by law.
- I consent to QatarEnergy Occupational Health section representatives in obtaining or exchanging further medical information from my treating doctors or other health practitioners, if required for the purposes of this medical assessment.
- My answers relating to my medical and employment history are true and complete to the best of my knowledge. Furthermore, there is nothing else regarding my health, well being or ability to carry out the duties of my proposed job which QatarEnergy Occupational Health may need to know to in order to assess me.
- I certify that the answers given by me on this medical questionnaire form are true, complete, and correct to the best of my knowledge and are made in good faith. I understand that false statements or omissions may void this medical exam.
- I understand and agree that this report and any related health information provided by me including investigations results may be supplied to other health professionals working for QatarEnergy / General Medical Commission, State of Qatar in order to establish my medical fitness to work.
- I have read and understood the conditions on this form.

Signature of Applicant	**Date**

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Part II – CLINICAL ASSESSMENT (TO BE COMPLETED BY MEDICAL STAFF)

9. NURSING EVALUATION *To be completed by Nursing staff (√ as appropriate)*

Height (Cm)	Weight (Kg)		BMI		Waist (Cm) If BMI above 30	BP	Pulse/Min	PEFR
Vision	Distant		Near		Colour Vision	Blood Group	Spoken Voice	
	RE	LE	RE	LE			R Ear	L Ear
Uncorrected					Normal Abnormal safe Abnormal unsafe		Normal	Normal
Corrected							Abnormal	Abnormal

10. CLINICAL EVALUATION *To be completed by Examining Medical Officer (N- Normal, X – Not examined, A- Abnormal)*

Please elaborate below any significant medical or surgical history, treatment and significant current findings, treatment.		
General features		
Head, Face, Neck		
Eyes		
Ears		
Nose, Mouth, Throat		
Lungs And Chest		
Cardiovascular		
Hematological		
Abdomen, Hernia		
Breast		
Gynecologic, Pregnancy		
Genitalia		
Anus, Rectum		
Urinary System		
Musculo- Skeletal		
Spine, Extremities		
Neurologic		
Mental Status		
Skin& Allergies		
Endocrine		
Metabolic		
Malignancy		

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(N- Normal, A- Abnormal, X- Not required) If any abnormal results please Use below space to elaborate your findings and recommendations.			*Any abnormal laboratory results, please mention below*
ECG			
Spirometry			
Audiometry			
VO_2 Max			
Chest X- Ray			

11. PHYSICIAN STATEMENT *To be completed by Examining Medical Officer*	
Please complete the following medical opinion based on the results of this medical assessment.(Tick only one)	
In my opinion, the candidate	**is**
	Fit for proposed position.
	Fit for proposed position after treatment for existing medical / surgical condition.
	Fit for proposed position except when requiring color vision.
	Fit for proposed position except when requiring normal hearing.
	Fit with restricted work duties.
	Has a condition requiring ongoing treatment.
	Requires specialist investigation before decision.
	Unfit for proposed position.
Please specify your recommendations in support of the above statement.	

Examining Medical Officer's Signature		**Official Stamp**

Name		Date	
Address			
Phone		Mobile	
E- Mail			