PRE-EMPLOYMENT / PERIODICAL MEDICAL EXAMINATION FORM

EMPLOYMENT'S	
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 ----------	Photo

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 loss Hearing 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: