

## Full Medical Report Form For Foreign Workers

All Parts in this Form are to be completed by a Singapore registered doctor. The foreign worker's Travel Document must be produced to the Examining Doctor for identification.

### Part I Personal Particulars of Foreign Worker

Name: \_\_\_\_\_ Passport No. \_\_\_\_\_ Sex: \*Male / Female Height: \_\_\_\_\_ cm  
 Occupation: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Citizenship: \_\_\_\_\_ Weight: \_\_\_\_\_ kg

### Part II Medical History (To be declared and signed by the foreign worker)

		Yes	No	If yes, give brief details			Yes	No	If yes, give brief details
1	Mental illness	<input type="checkbox"/>	<input type="checkbox"/>		6	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	
2	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>		7	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	
3	Chronic Asthma	<input type="checkbox"/>	<input type="checkbox"/>		8	Malaria	<input type="checkbox"/>	<input type="checkbox"/>	
4	Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>		9	Operations	<input type="checkbox"/>	<input type="checkbox"/>	
5	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>						

I declare that all the information given above is true and correct.

Signature of Foreign Worker \_\_\_\_\_

Date \_\_\_\_\_

### Part III Please tick if any of the Examinations/Tests is Abnormal and give brief details separately.

Clinical Examinations	Abnormal	Other Tests	Abnormal
1 Cardiovascular System	<input type="checkbox"/>	1 Chest X-ray – to be taken in Singapore	<input type="checkbox"/>
a Blood Pressure			
Systolic:			
Diastolic:			
b Heart Disease		<input type="checkbox"/>	2 Urine
c ECG (compulsory for male Thai workers & others above age 50, and in younger applicants where it is indicated, e.g. persons with cardiac murmurs or symptoms suggestive of Myocardial ischaemia)	<input type="checkbox"/>	a Albumin	<input type="checkbox"/>
d Severe varicose veins	<input type="checkbox"/>	b Sugar	<input type="checkbox"/>
2 Anaemia (if clinically anaemic, do HB: _____ g%)	<input type="checkbox"/>	c Pregnancy Test	<input type="checkbox"/>
3 Respiratory System	<input type="checkbox"/>	3 VDRL	<input type="checkbox"/>
4 Abdomen		4 Hearing-unable to hear ordinary conversation at 2m	<input type="checkbox"/>
a Hernia	<input type="checkbox"/>	5 Vision (should be at least 6/12 in both eyes with or without glasses.)	
b Enlarged Liver	<input type="checkbox"/>	a Vision Acuity	<input type="checkbox"/>
c Enlarged Spleen	<input type="checkbox"/>	i) Right eye	<input type="checkbox"/>
d Genito-Urinary System	<input type="checkbox"/>	ii) Left eye	<input type="checkbox"/>
5 Skin-Chronic Disease (e.g. leprosy, widespread eczema, psoriasis, etc)	<input type="checkbox"/>	b Colour Vision (for electricians & drivers only)	<input type="checkbox"/>
6 Locomotor/Neurological		c Any organic eye disease, e.g. Trachoma	<input type="checkbox"/>
a Significant limb amputation or deformity	<input type="checkbox"/>	6 Blood film for Malaria	<input type="checkbox"/>
b Limb movement and co-ordination	<input type="checkbox"/>	7 HIV (AIDS)	
c Significant spinal deformity	<input type="checkbox"/>	Note: HIV (AIDS) Test and blood film for Malaria must be done at laboratories approved by the Ministry of Health.	<input type="checkbox"/>
d Other significant abnormalities (in relation to the Work required to be performed)	<input type="checkbox"/>		
7 Endocrine disorders, e.g. thyrotoxicosis	<input type="checkbox"/>		
8 Mental state	<input type="checkbox"/>		

### Part IV Please tick in the box provided

Clinical examinations/tests (\*including/excluding ECG) required above are normal except those test results indicated "Abnormal" (if any) in Part III.

### Part V Certification from the Doctor (Any amendments must be endorsed by the Doctor who completes this Report)

I certify that I have examined the above-named foreign worker and found that this person is \*Fit / Unfit for employment in the above-stated occupation.

Name of Doctor: \_\_\_\_\_ Signature of Doctor: \_\_\_\_\_  
 (in BLOCK Letter)

Clinic Address: \_\_\_\_\_ Date: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

\*Delete where inapplicable

### Employers to Note:

Foreign Domestic Workers may be infected with various communicable diseases which can be transmitted to your family members including children through poor personal or food hygiene. These diseases include Cholera, Typhoid, Paratyphoid and Hepatitis B. It is therefore advisable that your worker is also screened for carrier of these diseases.