WORKAWAY
INTERNATIONAL

Employee Medical History

To be completed by all new hires and returners

Full Name_____**D.O.B.**_____**Phone**:_____
Address_____**Passport no**._____
Position:_____ **Country Club**: _____

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

CONDITION	YES	NO	CONDITION	YES	NO
Eye/Vision problems			Reproductive/Urinary disease		
Loss of Hearing			Kidney stones		
Allergies			Sexually transmited disease		
Skin disorders			HIV Infection		
Eczema			HIV related disease		
Psoriasis			Other		
Other			Hormonal Imbalances		
Heart problems			Diabetes		
Rheumatic fever			Thyroid problems		
High blood pressure			Other		
Other			Disease of Nervous system		
Respiratory System problems			Epilepsy		
Tuberculosis			Recurrent bouts of syncope		
Asthma			Psychiatric disease:		
Chronic bronchitis			Depression		
Allergic rhinitis			General anxiety		
Back and orthopaedic			Panic attacks		
Chronic backache			Schizophrenia		
Chronic neck pain			Drug/Alcohol dependency		
Back injuries			Other		
Neck injuries			Cancer		
Disc prolaps			Cancer treatment		
Arthritis			Medication		
Other			Chronic		
Disease of the intestinal tract:			Current		
Ulcers (gastric/duodenal)			Any other illness		
Chronic diarrhoea			Any Operations		
Jaundice			Family History		
Other			Illness		
			Operations		

Do you currently have any medical problems (in addition to the above mentioned ones)? YES ☐ NO ☐

Have you ever been declared medically unfit for work? YES ☐ NO ☐

For Females only:

Are you currently pregnant? YES ☐ NO ☐
How many pregnancies have you had? _____ How many children you have: _____
Last Menstrual Period: _____

If any of the above questions were answered „yes", please give details below:

_____
_____
_____
_____

I certify that the above medical information is true and correct. Further, I give my consent to release my test results to authorized Resort management for appropriate review, and authorize the Resort and its representatives to use the test results as a defense to any legal action to which I am a party.

Applicant Signature……. **Date……..**

Witnessed by …… **Date……..**

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Employee Physical Examination

To be completed by physician. Circle and check all that applies

Full Name_____**D.O.B.**_____**Phone**:_____

Height:_____ **Weight:** _____ **Body Mass Index:** _____ **Blood Pressure: L**_____ **R**_____ **Pulse:**_____

	Normal	Abnormal		Normal	Abnormal
Eye Vision			Varicose Veins		
Ear			Gastrointestinal Tract		
Nose			Endocryn System		
Throat			Uro-Genital System		
Dental			Skin		
Respiratory System			Central Nervous System		
Cardiovascular Sysyem			Locomor System		
Laboratory tests	**Normal**	**Abnormal**	**Laboratory tests**	**Normal**	**Abnormal**
CBC			HIV		
Blood Glucose			TPHA		
SGOT/SGPT			Hepatitis A		
Urinalysis			Hepatitis B		
Stool Analysis			Hepatitis C		

Functions/Problems to be checked when examining:

ENT (ear, Nose, Throat): Loss of Hearing; Otitis; Epistaxis: Nassal polypsl Septal deviation; Tonsillis, Tumors/Masses
Dental: Cavities; Good Hygiene; Gingivitis
Respiratory System: Constant cough; Sputum productions; Wheezing; Rhonchi
Cardiovascular System: Palpitations; Chest pain; Murmurs; Gallops; Hypertension; Cardiomegaly; Dyspnea on exertion; Pedal edema; Arrhythmia
Gastrointestinal Tract: Abdominal Pains; Diarrhoea; Constipation; Hemorrhoids; Hepatomegaly; Nausea
Endocrine System: Diabetes; Thyroid problems
Uro-Genital System: Pain on Urination; Hematuria; Veneral warts
Males: Varicocele; Scrotal Hernia
Females: Dysmenorrhea; Birth control
Skin Disorders: Lesions; Scars; Birthmarks; Jaundice; Discolorations; Eczema; Psoriasis; Tatoos
Central Nervous System: Cranial Nerves (1-12); Peripheral Nerves; Anxiety; Depression; Hallucinations; Tremors; Vertije
Locomotor System: Arthritis; Cervical Spine problems; Lumbar Spine Problems
Paraclinicallinvestigation: EKG, Chest X-Ray, Lumbar Spine X-Ray

Please document and comment on all abnormal/positive test results and physical findings in the space provided below

_____
_____
_____
_____
_____
_____
_____

Based on the clinical and paraclinical evaluation and tests, I declare Mr./Mrs._____
Fit/Unfit for duty (circle one)

Physician's Stamp

Physician's Printed Name:_____

Physician's Signature:_____

Date of Examination:_____