EMPLOYMENT HEALTH EXAMINATION FORM

……./……./20……

COMPANY		Photo
NAME		
SGK ID NUMBER		
ADRESS		
TELEPHONE		
E-MAIL		

I declare that I accept the staff health examınatıon and that the information I have given during the examination is correct and complete.

Name Surname
Signature

WORKER			
Name and Surname			
T.C. ID Number			
Birth Place and Date			
Gender			
Educational Status			
Marital Status		Number of Child	
Home Adress			
Tel No./e-mail			
Occupation			
Your Job			
Department			

Previously Worked Places (From this day to the past)	Sector	Your Job	Entry-Exit Date
1.			
2.			
3.			

Medical History	
Blood Type	
Congenital/Chronic Disease	
İmmunization	
- Tetanus	
- Hepatitis	
- Other	

Family history (chronic disease, immunization)

Mother	Father	Brother/Sister	Child

MEDICAL ANAMNESIS

1. Have you experienced any of the following complaints?	No	Yes
- Cough with phlegm		
- Shortness of breath		
- Chest pain		
- Palpitations		
- Back pain		
- Diarrhea or constipation		
- Pain in the joints		
2. Have you ever had any of the following diseases?	No	Yes
- Heart disease		
- Diabetes		
- Kidney disease		
- Jaundice		
- Stomach or duodenal ulcer		
- Hearing loss		
- Defect of vision		
- Nervous system disease		
- Skin disease		
- Food poisoning		

3. Have you been hospitalized?	No		İf yes, diagnosis?	
4. Have you had surgery?	No		İf yes, why?	

5. Have you had a work accident?	No		İf yes, what happened?	
6. Have you been subjected to examination related to the suspicion of Occupational Diseases?	No		If yes, the result?	
7. Have you received a disability?	No		If yes, what is it and rate?	
8. Are you currently receiving any treatment?	No		If yes, what is it?	

9. Do you smoke?	No				
	Quit		...............year ago	..........mth/yr smoked	...........pcs/day smoked
	Yes		...............year	.............pcs/day	
10. Do you drink alcohol?	No				
	Quit		...............year ago	..........mth/yr drank	.... frequently drank
	Yes		...............year	.... frequently	

PHYSICAL EXAMINATION RESULTS	
a) Sense Organs	
- Eye	
- Ear-Nose-Throat	
- Skin	
b) Cardiovascular System Examination	
c) Respiratory System Examination	
d) Digestive System Examination	
e) Urogenital System Examination	
f) Musculoskeletal Examination	
g) Neurological Examination	
h) Psychiatric Examination	
i) Other	
-TA: / mm-Hg	
-Pulse: / minutes	
-Height: Weight: Body Mass İndex :	

LABORATORY RESULTS	
A) Biological Analyzes	
- Blood	
- Urine	
B) Radiological Analyzes	
C) Physiological Analyzes	
- Audiometer	
- Pulmonary Function Test	
D) Psychological Tests	
E) Other	

OPINION AND CONCLUSIONS * :

1- …………………………………………………………………….................. is suitable for physical and mental work in his/her job.

2- He/She is suitable for working with the condition of ………………………………………………………………………………

Night or Shift **Work☐ / Not Work ☐**

At Height **Work☐ / Not Work ☐**

Indoors **Work☐ / Not Work ☐**

Name/Surname
Signature

OCCUPATIONAL PHYSICIAN
Name and Surname / SIGNATURE:
Diploma Date and Number:
Diploma Registration Date and No:
Occupational Medicine Certificate Date and No:

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