

Republic of the Philippines
Department of Labor and Employment
Bureau of Working Conditions

Occupational Health and Safety Division

ANNUAL MEDICAL REPORT FORM

For Period January 1, 19__ to December 31, 19__

1. Name of Establishment: _____
2. Address: _____
3. Name of Owner/Manager: _____
4. Nature of Business and Products/Service (Ex. Manufacturing, Textile) _____
5. Total Number of Employees: _____ Number of Shifts: _____
6. Number Distribution of Employees as to nature of workplace, sex and workshift

	Office	Production/Shop		
		1st Shift	2nd Shift	3rd Shift
Male:	_____	_____	_____	_____
Female:	_____	_____	_____	_____
Total:	_____	_____	_____	_____

7. Preventive Occupational Health Services: (Check or Cross)
- a. Occupational Health Services is organized/provided by:
- the establishment/undertaking
 - government authority/institution
 - other bodies/groups/institution (specify) _____
- b. Occupational Health services as described under 8a above, is organized/provided as a service:
- solely for the workers of the establishment/undertaking
 - common to a number of establishments/undertakings
- c. The employer engages the services of:
- Occupational health practitioner
Name: _____
Address: _____
 - Occupational health physician
Name: _____
Address: _____
 - Occupational health nurse
Name: _____
Address: _____
- d. The occupational health physician/practitioner/nurse/personnel conducts an inspection of the workplace:
- once every month
 - once every two (2) months
 - once every three (3) months
 - once every six (6) months
 - other details _____

8. emergency Occupational Health Services:
- a. The employer provides a treatment room/medical clinic in the workplace with medicines and facilities:
- Yes _____
 - No _____
 - others, please specify _____
- b. Schedule of attendance in the workplace:
- Workshift
- Occupational health physician: _____ hrs/day _____
- Occupational health practitioner: _____ hrs/day _____
- Occupational health nurse: _____ hrs/day _____

- c. Schedule of attendance of full-time first-aider:
 1st workshift
 2nd workshift
 3rd workshift
- d. The following occupational health personnel of this establishment have undergone training in occupational health and safety/first aid:
 occupational health physician
 occupational health nurse
 first-aider
 others, please specify _____

9. Occupational Health Services:

- a. The occupational health personnel of this establishment conducts regular appraisal of the sanitation system in the Workplace:
 Yes No
- b. Number of workers who underwent the following medical examinations:

	<u>Physical Exams</u>	<u>X-rays</u>	<u>Urinalysis</u>	
1. Pre-placement	_____	_____	_____	
2. Periodic	_____	_____	_____	
3. Return-to-work	_____	_____	_____	
4. Transfer	_____	_____	_____	
5. Special	_____	_____	_____	
6. Separation	_____	_____	_____	
	<u>Stool Exams</u>	<u>Blood Test</u>	<u>ECG</u>	<u>Others</u>
1. Pre-placement	_____	_____	_____	_____
2. Periodic	_____	_____	_____	_____
3. Return-to-work	_____	_____	_____	_____
4. Transfer	_____	_____	_____	_____
5. Special	_____	_____	_____	_____
6. Separation	_____	_____	_____	_____

10. Report of Diseases

- a. Number of cases diagnosed/treated for the following diseases ((/ of X):

	<u>Male</u>	<u>Female</u>	<u>Total Number of Cases</u>
Skin:			
<input type="checkbox"/> allergy	_____	_____	_____
<input type="checkbox"/> dermatoses	_____	_____	_____
<input type="checkbox"/> infection as folliculitis/absecess/paronychia	_____	_____	_____
<input type="checkbox"/> Others	_____	_____	_____
Head:			
<input type="checkbox"/> migraine headache	_____	_____	_____
<input type="checkbox"/> tension headache	_____	_____	_____
<input type="checkbox"/> Others	_____	_____	_____
Eyes:			
<input type="checkbox"/> Error of refraction	_____	_____	_____
<input type="checkbox"/> Bacterial/Viral conjunctivities	_____	_____	_____
<input type="checkbox"/> Cataract	_____	_____	_____
<input type="checkbox"/> Others	_____	_____	_____
Mouth & ENT:			
<input type="checkbox"/> Gingivitis	_____	_____	_____
<input type="checkbox"/> Herpes Labiales/nasalis	_____	_____	_____
<input type="checkbox"/> Otitis Media/Externa	_____	_____	_____
<input type="checkbox"/> Deafness	_____	_____	_____
<input type="checkbox"/> Meniere's Syndrome/Vertigo	_____	_____	_____
<input type="checkbox"/> Rhinitis/Colds	_____	_____	_____
<input type="checkbox"/> Nasal Polyps	_____	_____	_____
<input type="checkbox"/> Sinusitis	_____	_____	_____
<input type="checkbox"/> Tonsillopharyngitis	_____	_____	_____
<input type="checkbox"/> Laryngitis	_____	_____	_____
<input type="checkbox"/> Others	_____	_____	_____

	<u>Male</u>	<u>Female</u>	<u>Total Number of Cases</u>
Respiratory:			
<input type="checkbox"/> Bronchitis	_____	_____	_____
<input type="checkbox"/> Bronchial Asthma	_____	_____	_____
<input type="checkbox"/> Pneumonia	_____	_____	_____
<input type="checkbox"/> Tuberculosis	_____	_____	_____
<input type="checkbox"/> Pneumoconiosis	_____	_____	_____
<input type="checkbox"/> Others	_____	_____	_____
Heart and Blood Vessel:			
<input type="checkbox"/> Hypertension	_____	_____	_____
<input type="checkbox"/> Hypotension	_____	_____	_____
<input type="checkbox"/> Angina Pectoris	_____	_____	_____
<input type="checkbox"/> Myocardial Infarction	_____	_____	_____
<input type="checkbox"/> Vascular disturbances in extremities due to continuous vibration	_____	_____	_____
<input type="checkbox"/> Others	_____	_____	_____
Gastrointestinal:			
<input type="checkbox"/> Gastroenteritis/Diarrhea	_____	_____	_____
<input type="checkbox"/> Amoebiasis	_____	_____	_____
<input type="checkbox"/> Gastritis/Hyperacidity	_____	_____	_____
<input type="checkbox"/> Appendicitis	_____	_____	_____
<input type="checkbox"/> Infectious Hepatitis	_____	_____	_____
<input type="checkbox"/> Liver Cirrhosis	_____	_____	_____
<input type="checkbox"/> Hepatic Abscess	_____	_____	_____
<input type="checkbox"/> Cancer (Hepatic/Gastric)	_____	_____	_____
<input type="checkbox"/> Others	_____	_____	_____
Genito-Urinary:			
<input type="checkbox"/> Urinary Tract Infection	_____	_____	_____
<input type="checkbox"/> Stones	_____	_____	_____
<input type="checkbox"/> Cancer	_____	_____	_____
<input type="checkbox"/> Others	_____	_____	_____
Reproductive:			
<input type="checkbox"/> Dysmenorrhea	_____	_____	_____
<input type="checkbox"/> Infection (Cervicitis) (Vaginitis)	_____	_____	_____
<input type="checkbox"/> Abortion (Spontaneous) (Threatened)	_____	_____	_____
<input type="checkbox"/> Hyperemesis Gravidarum	_____	_____	_____
<input type="checkbox"/> Uterine Tumors	_____	_____	_____
<input type="checkbox"/> Cervical Polyp/Cancer	_____	_____	_____
<input type="checkbox"/> Ovarian Cyst/Tumors	_____	_____	_____
<input type="checkbox"/> Sexually-Transmitted Diseases	_____	_____	_____
<input type="checkbox"/> Hernia (Inguinal) (Femoral)	_____	_____	_____
<input type="checkbox"/> Others	_____	_____	_____
Neuromuscular/Skeletal/Joints:			
<input type="checkbox"/> Peripheral Neuritis	_____	_____	_____
<input type="checkbox"/> Torticollis	_____	_____	_____
<input type="checkbox"/> Arthritis	_____	_____	_____
<input type="checkbox"/> Others	_____	_____	_____
Lymphatics and Circulatory:			
<input type="checkbox"/> Anemia	_____	_____	_____
<input type="checkbox"/> Leukemia	_____	_____	_____
<input type="checkbox"/> Cerebrovascular Accidents	_____	_____	_____
<input type="checkbox"/> Lymphadenitis	_____	_____	_____
<input type="checkbox"/> Lymphoma	_____	_____	_____
Infectious Diseases:			
<input type="checkbox"/> Influenza	_____	_____	_____
<input type="checkbox"/> Typhoid/Paratyphoid Fever	_____	_____	_____
<input type="checkbox"/> Cholera	_____	_____	_____
<input type="checkbox"/> Measles	_____	_____	_____

	<u>Male</u>	<u>Female</u>	<u>Total Number of Cases</u>
() Mumps	_____	_____	_____
() Tetanus	_____	_____	_____
() Malaria	_____	_____	_____
() Schistosomiasis	_____	_____	_____
() Herpes Zoster	_____	_____	_____
() Chicken Fox	_____	_____	_____
() German Measles	_____	_____	_____
() Rabies	_____	_____	_____
() Others	_____	_____	_____
Diseases due to Physical Environment:			
() Diseases due to abnormalities in temperature and humidity	_____	_____	_____
() Diseases due to abnormalities in air pressure	_____	_____	_____
() Poisoning/Overdosage to Chemicals	_____	_____	_____
TOTAL NUMBER	_____	_____	_____

11. Report of Occupational Accidents/Injuries

<u>Nature</u>	<u>Male</u>	<u>Female</u>	<u>Parts of Body Affected</u> <u>Total Number of Cases</u>
Contusion, bruises, hematoma	_____	_____	_____
Abrasions	_____	_____	_____
Cuts, Lacerations, punctures	_____	_____	_____
Concussion	_____	_____	_____
Avulsion	_____	_____	_____
Amputation, loss of body parts	_____	_____	_____
Crushing injuries	_____	_____	_____
Spinal injuries	_____	_____	_____
Cranial injuries	_____	_____	_____
Sprains	_____	_____	_____
Dislocation/Fractures	_____	_____	_____
Chemical Burns	_____	_____	_____

12. Immunization Program (Indicate the number)

Tetanus Taxoid Injection	_____	_____	_____
Tetanus Antitoxin Injection	_____	_____	_____
Tetanus Globulin Injection	_____	_____	_____
Anti-Cholera, Anti-Typhoid Triple Vaccine	_____	_____	_____
Others (Please specify)	_____	_____	_____

13. Keeping of Medical-Records of Workers (Please check) () done () not done

14. Health Education and Counselling by Health and Safety Personnel:
 (Please check one or more)
 () done individually as each worker comes to the clinic for consultation.
 () done in organized group discussions/seminars.
 () done with the use of visual displays and/or promotional materials, leaflets, etc.

15. Other Health Programs

	<u>Seminar</u>	<u>Use of Visual Aid/ Materials</u>	<u>Counselling</u>
Nutrition Program Maternal and Childcare Program Family Planning Program Mental Health Activities Personal Health Maintenance			

Physical Fitness Program: (Please check)

- Sports Activities Yes No
- Recreation Activities Yes No
- Others (Please specify) Yes No

16. Hazards in the Workplace: (Please check and give details of the active substance)

	<u>Substances and/or Sources</u>	<u>Number of Workers Exposed</u>
a. Chemicals Hazards:		
<input type="checkbox"/> dust (Ex. Silica dust)	_____	_____
<input type="checkbox"/> liquids (Ex. Mercury)	_____	_____
<input type="checkbox"/> mist/fumes/vapors (Ex. Mist from paint spraying)	_____	_____
<input type="checkbox"/> gas (Ex. CO, H ₂ S)	_____	_____
<input type="checkbox"/> others (please specify)	_____	_____
b. Physical Hazards:		
<input type="checkbox"/> noise	_____	_____
<input type="checkbox"/> temperature/humidity	_____	_____
<input type="checkbox"/> pressure	_____	_____
<input type="checkbox"/> illumination	_____	_____
<input type="checkbox"/> radiation/ultraviolet/microwave	_____	_____
<input type="checkbox"/> others (please specify)	_____	_____
c. Biological Hazards:		
<input type="checkbox"/> Viral	_____	_____
<input type="checkbox"/> Bacterial	_____	_____
<input type="checkbox"/> Fungal	_____	_____
<input type="checkbox"/> Parasitic	_____	_____
<input type="checkbox"/> Others	_____	_____
d. Ergonomic Stress:		
<input type="checkbox"/> Exhausting physical work	_____	_____
<input type="checkbox"/> Prolonged standing	_____	_____
<input type="checkbox"/> Low Back Pain	_____	_____
<input type="checkbox"/> Unfavorable work posture	_____	_____
<input type="checkbox"/> Static/monotonous work	_____	_____
<input type="checkbox"/> Others, specify	_____	_____

Submitted by:

Medical Personnel/Title

Date

Noted by:

Employer