

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE
ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Surname/
Forenames *AHWAQ SUWAID HAMIDAN
SUWAID AL HAMIDI*

Nationality *OMANI*

Mobile No. *92797870* Home/Leave Address: *OMAN* Company Number: *104100001* Reference Indicator: *7519699*

Personal Details *DOB - 30/10/88*

A Male Female Married Single Separated /Divorced /Widow(er)

Relationship to employee

Wife Son Daughter No of Children: *1*

Reason for Examination (tick as appropriate)

Periodic Medical Examination Final / Retirement Other Reason:

Employee only

B Present Job and Location: *Driver / Driver* Next Job and Location: *Driver / Driver*

Are you a registered person with special needs? Do you belong to any Medical Insurance Scheme?

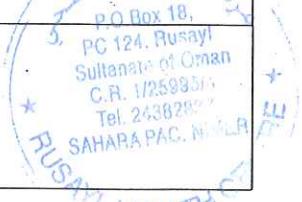
Previous Medical History: All important medical events should be listed and dated at every medical examination. To be completed together with the interviewing Nurses or Doctor who will be able to help by referring to your notes.

Please answer the following questions and tick 'N' (no) or 'Y' (yes) in the column. If 'Y' Please describe

	N	Y	Description
Have you, since your last medical been treated by your family doctor or specialist for significant (major) ailments?	<input checked="" type="checkbox"/>		
1 Ear, nose, eye or throat problems	<input checked="" type="checkbox"/>		
2 Chest problems like asthma, bronchitis, other bad cough	<input checked="" type="checkbox"/>		
3 Heart abnormality, chest pains	<input checked="" type="checkbox"/>		
4 Abdominal pains, abnormal bowel motions	<input type="checkbox"/>		
5 Urogenital problems (kidney disease, menstrual disorder)	<input type="checkbox"/>		
6 Skin trouble or allergies	<input type="checkbox"/>		
7 Epileptic fits, dizzy spells or migraine	<input type="checkbox"/>		
8 History of mental illness, depression anxiety	<input type="checkbox"/>		
9 Diabetes, thyroid disease	<input type="checkbox"/>		
10 Blood disorder e.g. anaemia, blood cancer e.g. leukaemia	<input type="checkbox"/>		
11 Any history of accidents or fractures	<input type="checkbox"/>		
12 Have you had any serious allergies	<input type="checkbox"/>		
13 Do any dependants have a significant ongoing illness?	<input type="checkbox"/>		
14 Any family history of cancers	<input type="checkbox"/>		
Do you take any regular medicines, or have you taken in the past?	<input checked="" type="checkbox"/>		
Do you smoke? If yes, what and how much each day?	<input checked="" type="checkbox"/>		
Do you drink alcohol? If yes, what is your average weekly intake?	<input checked="" type="checkbox"/>		
Have you ever taken elicited/recreational drugs?	<input checked="" type="checkbox"/>		
Are you doing regular sports or physical activities?	<input checked="" type="checkbox"/>		

STATEMENT: I have read the above questions and the above answers are correct and no information concerning my present or past state of health has been withheld. I understand and agree that this form will be held as a confidential record by PDO Medical Department, and may be copied (by paper or secure electronic transmission) to the Occupational Health Services for the purpose of Health Surveillance and other Occupational Health review.

Date: *14/11/21* Signature of Applicant: *[Signature]*



FOR COMPLETION BY EXAMINING DOCTOR OR NURSE

Further details of medical history and recreational activities

N = Normal A = Abnormal (please describe)			PHYSICAL EXAMINATION						
N	A								
<input checked="" type="checkbox"/>		1. Eyes & Pupils							
<input checked="" type="checkbox"/>		2. E.N.T.							
<input checked="" type="checkbox"/>		3. Teeth & Mouth							
<input checked="" type="checkbox"/>		4. Lungs & Chest							
<input type="checkbox"/>		5. Cardiovascular System							
<input type="checkbox"/>		6. Abdo. Viscera							
<input type="checkbox"/>		7. Hernial Orifices							
<input type="checkbox"/>		8. Anus & Rectum							
<input type="checkbox"/>		9. Genito-urinary							
<input type="checkbox"/>		10. Extremities							
<input type="checkbox"/>		11. Musculo-skeletal							
<input checked="" type="checkbox"/>		12. Skin & Varicose Vns.							
<input checked="" type="checkbox"/>		13. C.N.S.							
HEIGHT cm 161	WEIGHT kg 113	BMI 43.6	B.P. 130 70 mmHg	PULSE 80 /mins.	HEARING L M R X	Uncorrected Corrected	DISTANT R L	NEAR R L	VISION 6/6 6/6 N/N clear

N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS			N	A	
		1. Urinalysis					7. Audiogram
		2. Hb, Bloodcount, ESR					8. Lung Function
		3. LFT, RFT, RBS					9. Chest X-Ray
		4. Drug Screen					10. ECG
		5. Lipids (40 years +)					11. CVS risk for 40 yrs. & above
		6. Sickle Cell test					12. HIV, Hepatitis screening

OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)

✓ Obesity → Refer to dietitian for diet
 ✓ Pneumoscopy heavy loss refer to ENT surgeon within 3 months (Referral attached)

ASSESSMENT AND RECOMMENDATIONS:

FIT ALL AREAS FIT WITH RESTRICTION TEMPORARY UNFIT UNFIT

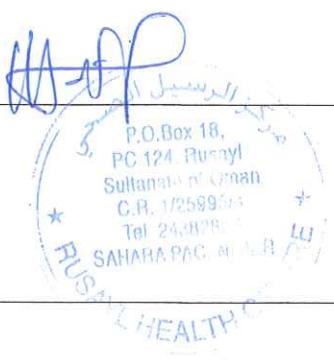
REVIEW/CONSULTATION

Date:

Name (Block Capitals): Dr. / Nurse



Signature:



Date:

Name (Block Capitals): Dr. / Nurse

Signature: