



مرکز الرسیل الصحي RUSAYL HEALTH CENTRE

ISO 9001 - 2015 Certified Co.

No. B15463

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE

ISO 9001 - 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Surname/Forenames: Tawel Saleem		
Nationality: Pakistan		
Mobile No: 71348980	Home/Leave Address: Pakistan	
Company Number: 1679	Reference Indicator: Truckman	
Personal Details: 30y 1 Dob - 05.03.1992 / ID - 111084075		
A <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female <input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced /Widow(er)		
Home/Leave Address: <input type="checkbox"/> Relationship to employee: <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter No of Children:		
Reason for Examination (tick as appropriate)		
Periodic Medical Examination <input checked="" type="checkbox"/> Final / Retirement <input type="checkbox"/> Other Reason: <input type="checkbox"/>		
Employee only		
B Present Job and Location: Heider Next Job and Location: N.M.V		
Are you a registered person with special needs? <input type="checkbox"/> Do you belong to any Medical Insurance Scheme? <input type="checkbox"/>		
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?		
1	Ear, nose, eye or throat problems	
2	Chest problems like asthma, bronchitis, other bad cough	
3	Heart abnormality, chest pains	
4	Abdominal pains, abnormal bowel motions	
5	Urogenital problems (kidney disease, menstrual disorder)	
6	Skin trouble or allergies	
7	Epileptic fits, dizzy spells or migraine	
8	History of mental illness, depression anxiety	
9	Diabetes, thyroid disease	
10	Blood disorder e.g. anaemia, blood cancer e.g. leukaemia	
11	Any history of accidents or fractures	
12	Have you had any serious allergies	
13	Do any dependants have a significant ongoing illness?	
14	Any family history of cancers	
Do you take any regular medicines, or have your taken in the past?		
Do you smoke? If yes, what and how much each day?		
Do you drink alcohol? If yes, what is your average weekly intake?		
Have you ever taken elicited/recreational drugs?		
Are you doing regular sports or physical activities?		
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: 26/05/2022	Signature of Applicant: [Signature]	





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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	
		1. Eyes & Pupils
		2. E.N.T.
		3. Teeth & Mouth
		4. Lungs & Chest
		5. Cardiovascular System
		6. Abdo. Viscera
		7. Hernial Orifices
		8. Anus & Rectum
		9. Genito-urinary
		10. Extremities
		11. Musculo-skeletal
		12. Skin & Varicose Vns.
		13. C.N.S.

HEIGHT cm	WEIGHT kg	BMI	B.P.	PULSE	HEARING	DISTANT	NEAR
163	63	24	112/80	76/min.	L Normal R Normal	R L Uncorrected Corrected	R L 6/6 6/6

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.)

NA I)

ASSESSMENT AND RECOMMENDATIONS:

☒ FIT ALL AREAS ☐ FIT WITH RESTRICTION ☐ TEMPORARY UNFIT ☐ UNFIT

Date:

Name (Block Capitals): Dr. / Nurse

Signature:

REVIEW/CONSULTATION

Date:

Name (Block Capitals): Dr. / Nurse

Signature:

