



ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE
ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Mobile No: 71348980	Home/Leave Address: pakistan	Surname/Forenames: Jawed Saleem
		Nationality: Pakistani
		Company Number: 1679
		Reference Indicator: Trackman

Personal Details	30y	1	Dob - 05,03,1992	170-111084075
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"/> Wife	<input type="checkbox"/> Son	<input type="checkbox"/> Daughter	No of Children:
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Reason for Examination (tick as appropriate)	<input checked="" type="checkbox"/> Periodic Medical Examination	<input type="checkbox"/> Final / Retirement	<input type="checkbox"/> Other Reason:
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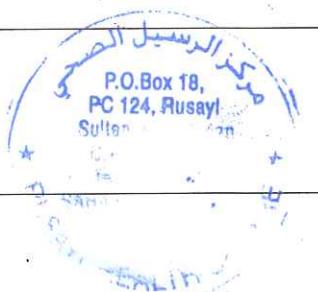
Employee only	B Present Job and Location: Dealer	Next Job and Location: N/MV
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Are you a registered person with special needs? <input type="checkbox"/>	Do you belong to any Medical Insurance Scheme? <input type="checkbox"/>
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Previous 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.

		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 you 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: J.S.
Signature of Applicant: J.S.	
	

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		3					
		2. E.N.T.							
		3. Teeth & Mouth							
		4. Lungs & Chest							
		5. Cardiovascular System		NA 1)					
		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 76 0 mins.	HEARING L Normal R Normal Uncorrected Corrected	DISTANT R L	VISION R L 6/6	NEAR R L 6/6	
163	63	24	117 80						
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 1)

ASSESSMENT AND RECOMMENDATIONS:

FIT ALL AREAS FIT WITH RESTRICTION TEMPORARY UNFIT UNFIT

DR. SANATH BUDDHAPRATADARSHAN
GENERAL PRACTITIONER
RUSAYL HEALTH CENTRE
MOH LIC NO. 16042

26/05/2022
Date:

Name (Block Capitals): Dr. / Nurse


Signature:

REVIEW/CONSULTATION

Date:

Name (Block Capitals): Dr. / Nurse

Signature:

