

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE
ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Surname/Forenames *Kayum Eddries*

Nationality *Bangladesh*

Company Number: *1660*

Reference Indicator:

Mobile No. *74217098* Home/Leave Address: *17 D-03 - 09, 04, 1989 / ID - 107047913*

Personal Details *33y* A Male Female Married Single Separated /Divorced /Widow(er)

Home/Leave Address: Relationship to employee
 Wife Son Daughter No of Children:

Reason for Examination (tick as appropriate)

Periodic Medical Examination Final / Retirement Other Reason:

Employee only

B Present Job and Location: *Helper* Next Job and Location: *Munnu 1*

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?			
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?			

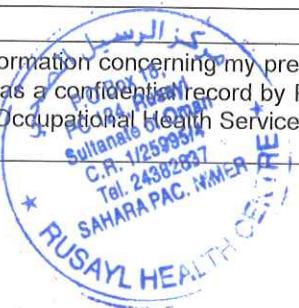
STATEMENT: I have read the above questions and the above answers are correct and no information concerning my present or past state of health has been withheld. I understand and agree that this form will be held as a confidential record by PDO Medical Department, and may be copied (by paper or secure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

17/02/2022

KAYUM

Date:

Signature of Applicant:



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 162	WEIGHT kg 76	BMI 29	B.P. 118 82	PULSE 66 /mins.	HEARING L R	Normal Normal Uncorrected Corrected	DISTANT R L	VISION NEAR R L
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.)

A advise on 100% fat area.
Regular exercise

ASSESSMENT AND RECOMMENDATIONS:

FIT ALL AREAS

FIT WITH RESTRICTION

TEMPORARY UNFIT

UNFIT

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

Date:

Name (Block Capitals): Dr. / Nurse


Signature:



REVIEW/CONSULTATION

Date:

Name (Block Capitals): Dr. / Nurse

Signature: