

1404

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS



مركز الرعاية الصحية  
RUSAYL HEALTH CENTRE  
NIMR, FAHUD, QARNALAM, BHAJA, SAHRIWAL, MARXUL

INITIAL EXAMINATION REPORT

Place of examination <b>Bahja</b>	Date <b>9-1-19</b>	Surname <b>Mohammed Kaium</b>
Forenames <b>DOB - 5-9-21, CN - 100200758</b>		Address <b>Truckman e Bahja e Haina</b>
Home Telephone number <b>79054744</b>		

If a dependant or fancee entr employees name jere :-

Surname :

Forenames:

Nationality <b>Bangladesh</b>		Country of birth <b>Bangladesh</b>	Religion <b>Islam</b>
<input checked="" type="checkbox"/> Male	<input checked="" type="checkbox"/> Single	<input type="checkbox"/> Widow(er)	Relationship to employee <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input checked="" type="checkbox"/> Fiancee
<input type="checkbox"/> Female	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced <input type="checkbox"/> Separated	
Number of Children <b>-</b>			

Reason for examination ☐ Pre-employment  
**POO medical** ☐ Pre-overseas

Job :- **Helper**  
Area:- **Haina**

Name and address of family doctor

List your last 3 jobs

(1)

(2)

(3)

Are you Registered Disabled Person? (UK

☐

Do you belong to any Medical Insurance Scheme?

☐

DO YOU HAVE OR HAVE YOU HAD :- (Tick 'yes' or 'No' column or put a (?) If uncertain exclude minor ailments.)

	Y	N		Y	N		Y	N
1. Sirius rouble		<input checked="" type="checkbox"/>	22. Heart Disease		<input checked="" type="checkbox"/>	42. Awarded benifities for Industrial injury/illness		<input checked="" type="checkbox"/>
2. Neck swellings/flands		<input checked="" type="checkbox"/>	23. Rheumatic Fever		<input checked="" type="checkbox"/>	43. Treated for a mental condition. eg . depression		<input checked="" type="checkbox"/>
3. Difficulty in vision		<input checked="" type="checkbox"/>	24. Abnormal heartbeat		<input checked="" type="checkbox"/>	44. Treated for problem drinking or drug abuse		<input checked="" type="checkbox"/>
4. Any ear discharge		<input checked="" type="checkbox"/>	25. High blood pressure		<input checked="" type="checkbox"/>	45. Exposed to toxic substance or noise		<input checked="" type="checkbox"/>
5. Asthma/bronchitis		<input checked="" type="checkbox"/>	26. Stroke		<input checked="" type="checkbox"/>	FOR WOMEN ONLY		
6. Hayfever/other allergy		<input checked="" type="checkbox"/>	27. Serious chest pain		<input checked="" type="checkbox"/>	Have you aver had:-		
7. Any skin trouble		<input checked="" type="checkbox"/>	28. Any blood disease		<input checked="" type="checkbox"/>	46. An abnormal smear		
8. Tuberculosis		<input checked="" type="checkbox"/>	29. Kidney disease		<input checked="" type="checkbox"/>	47. Any gynaecological treatment		
9. Shortness of breath		<input checked="" type="checkbox"/>	30. Painful passage of urine		<input checked="" type="checkbox"/>	48. Are you pregnant?		
10. Coughed/vomited blood		<input checked="" type="checkbox"/>	31. Blood in urine		<input checked="" type="checkbox"/>	49. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE ?		
11. Severe abdominal pain		<input checked="" type="checkbox"/>	32. Diabetes		<input checked="" type="checkbox"/>			
12. Stomach ulcer		<input checked="" type="checkbox"/>	33. Headaches /migraine		<input checked="" type="checkbox"/>			
13. Recurrent indigestion		<input checked="" type="checkbox"/>	34. Dizziness/tainting		<input checked="" type="checkbox"/>			
14. Jaundice or hepatitis		<input checked="" type="checkbox"/>	35. Epilepsy		<input checked="" type="checkbox"/>			
15. Gall bladder disease		<input checked="" type="checkbox"/>	36. Joints/spinal trouble		<input checked="" type="checkbox"/>			
16. Marked change in bowel habits		<input checked="" type="checkbox"/>	37. Surgical operation		<input checked="" type="checkbox"/>			
17. Blood in stools (motions)		<input checked="" type="checkbox"/>	38. Serious accident /tracture		<input checked="" type="checkbox"/>			
18. Marked change in weight		<input checked="" type="checkbox"/>	39. Tropical disease		<input checked="" type="checkbox"/>			
19. Varicose veins		<input checked="" type="checkbox"/>	40. Fear of heights		<input checked="" type="checkbox"/>			
20. Lump in breast/armpit		<input checked="" type="checkbox"/>	HAVE YOU EVER BEEN:-		<input checked="" type="checkbox"/>			
21. Cancer		<input checked="" type="checkbox"/>	41. Rejected for employment or insurance for medical reasons		<input checked="" type="checkbox"/>			

How much tabacco each day ?

**3 st ( day**

Average daily alcohol consumption

**NA**

Family history	Diabetes <input checked="" type="checkbox"/>	Tuberculosis <input checked="" type="checkbox"/>	Epilepsy <input checked="" type="checkbox"/>	Asthama <input checked="" type="checkbox"/>	Eczema <input checked="" type="checkbox"/>
	Heart disease <input checked="" type="checkbox"/>	High blood pressure <input checked="" type="checkbox"/>	Stroke <input checked="" type="checkbox"/>	Cancer <input checked="" type="checkbox"/>	Blood disease <input checked="" type="checkbox"/>

PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT :-

I declare these statements to be true to the best of my knowledge and belief and I agree that the result of this medical in general terms may be revealed to the company if required, and the details sent to my own doctor if this is considered necessary by the examining medical officer.

Date **9-1-19** Signature of applicant **Kaium**

FOR COMPLETION BY EXAMINING DOCTOR OR SISTER  
FURTHER DETAILS OF MEDICAL HISTORY AND RECREATIONAL ACTIVITIES

N - Normal A - Abnormal Please Describe		PHYSICAL EXAMINATION																	
N	A	1. Eyes & Pupils	• Bmi: 31.2 kg/m <sup>2</sup>																
<input checked="" type="checkbox"/>		2. E.N.T.																	
<input checked="" type="checkbox"/>		3. Teeth & Mouth																	
<input checked="" type="checkbox"/>		4. Lungs & Chest																	
<input checked="" type="checkbox"/>		5. Cardiovascular System																	
<input checked="" type="checkbox"/>		6. Abdo. Viscera																	
<input checked="" type="checkbox"/>		7. Hernial Orifices																	
<input checked="" type="checkbox"/>		8. Anus & Rectum																	
<input checked="" type="checkbox"/>		9. Genito - urinary																	
<input checked="" type="checkbox"/>		10. Extremities																	
<input checked="" type="checkbox"/>		11. Muscula-skeletal																	
<input checked="" type="checkbox"/>		12. Skin & Varicose Vns.																	
<input checked="" type="checkbox"/>		13. C.N.S.																	
<input checked="" type="checkbox"/>		14. Breasts																	
		15.																	
HEIGHT cm		WEIGHT kg		B.P.		HEARING		HEARING		VISION:		DISTANT		NEAR		COLOUR VISION		BLOOD GROUP	
162		82		119/80 mmHg		L R		L R		Uncorrected Corrected		R L		R L		•			
N		A		LABORATORY AND SPECIAL INVESTIGATIONS															
<input checked="" type="checkbox"/>				• dyslipidemia															
<input checked="" type="checkbox"/>				1. Urinalysis															
<input checked="" type="checkbox"/>				2. Hb Bloodcount ESR															
<input checked="" type="checkbox"/>				3. Serum Profile															
<input checked="" type="checkbox"/>				4. Stool															
<input checked="" type="checkbox"/>				5. E.C.G.															
				6. Audiogram															
				7. Lung Function															
				8. Chest X-Ray															
				9. Drug Screen															
				10. CR Screen															

OTHER FINDINGS (physique, scars, disabilities, mental stability etc.)

• Bmi: obese

Adv: • regular physical exercise  
• Avoid extra calories and fatty foods.  
• visit your doctor for dyslipidemia Rx.

ASSESSMENT

☒ FIT ALL AREAS ☐ FIT HOME SERVICES ONLY ☐ UNFIT/UNSUITABLE ☐ MAY BE REASSESSED

Date 13.01.19 Signature

DR. MOHAMMAD MARUF FERDOUS  
Name (Block Capitals) MEDICAL OFFICER  
RUSAYL HEALTH CENTRE  
MOH LIC NO. 12930

Doctor / Sister

REVIEW/CONSULTATION

Date

Signature

Name (Block Capitals)

Doctor / Sister

