

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE
ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Surname/ Forenames		MALIK SHAHZAD KHAN	
Nationality		PAKISTANI	
Mobile No.	97900688	Home/Leave Address:	Company Number:

Reference Indicator:

Age - 34 yrs

Personal Details

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:	Relationship to employee <input checked="" type="checkbox"/> 2 Wife <input checked="" type="checkbox"/> 2 Son <input type="checkbox"/> 3 Daughter
No of Children: 5	

Reason for Examination (tick as appropriate)

Periodic Medical Examination Final / Retirement Other Reason:

Employee only

B Present Job and Location: Crane Operator / Marmal Next Job and Location: Truck 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

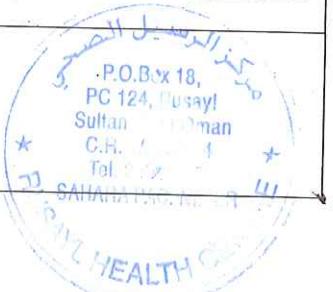
		N	Y	Description
Have you, since your last medical been treated by your family doctor or specialist for significant (major) ailments?				
1 Ear, nose, eye or throat problems				
2 Chest problems like asthma, bronchitis, other bad cough				
3 Heart abnormality, chest pains				
4 Abdominal pains, abnormal 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?			✓	Occasionally
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: 3/10/22

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							
		1. Eyes & Pupils						
		2. E.N.T.						
		3. Teeth & Mouth						
		4. Lungs & Chest						
		5. Cardiovascular System						
		6. Abdo. Viscera						
		7. Hernial Orifices						Normal
		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. 120 80 mmHg	PULSE 72/mins.	HEARING L M R N	VISION		
182	101	30.5			Uncorrected Corrected	DISTANT R 6 L 6	NEAR R L L R	
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.)

ASSESSMENT AND RECOMMENDATIONS:

FIT ALL AREAS FIT WITH RESTRICTION TEMPORARY UNFIT UNFIT

Date:

31/10/22

Name (Block Capitals): Dr. / Nurse

Signature:

REVIEW/CONSULTATION

Date:

Name (Block Capitals): Dr. / Nurse

Signature:

