



TRUCK - OMAN

Appendix 33: EX2 Form (Routine/Periodic Medical Examination)

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL -
CONFIDENTIAL)

ID 17868 Reg-Dt 31/01/2023

RAMIZ HUSSAIN

Male Nationality PAKISTANI

Development Oman
MEDICAL DEPARTMENTPLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALSSurname/
Forenames RAMIZ HUSSAIN

Nationality PAKISTANI DOB #17/09/1980

Mobile No. 92687845

Address: 92234771

Company Number:

Reference Indicator:

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)
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Home/Leave Address:	<input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	No of Children: 1
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Reason for Examination (tick as appropriate)

Periodic Medical Examination <input checked="" type="checkbox"/>	Final / Retirement <input type="checkbox"/>	Other Reason: <input type="checkbox"/>
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Employee only

B Present Job and Location: HEAVY DRIVE 12 - HAIMA	Next Job and Location:
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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.

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?	<input checked="" type="checkbox"/>		
1 Ear, nose, eye or throat problems	<input checked="" type="checkbox"/>		
2 Chest problems like asthma, bronchitis, another bad cough	<input checked="" type="checkbox"/>		
3 Heart abnormality, chest pains	<input checked="" type="checkbox"/>		
4 Abdominal pains, abnormal bowel motions	<input checked="" type="checkbox"/>		
5 Urogenital problems (kidney disease, menstrual disorder)	<input checked="" type="checkbox"/>		
6 Skin trouble or allergies	<input checked="" type="checkbox"/>		
7 Epileptic fits, dizzy spells or migraine	<input checked="" type="checkbox"/>		
8 History of mental illness, depression anxiety	<input checked="" type="checkbox"/>		
9 Diabetes, thyroid disease, history of Hypertension	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	DM on treatment
10 Blood disorder e.g. anaemia, blood cancer e.g. leukaemia	<input checked="" type="checkbox"/>		
11 Any history of accidents or fractures	<input checked="" type="checkbox"/>		
12 Have you had any serious allergies	<input checked="" type="checkbox"/>		
13 Do any dependants have a significant ongoing illness?	<input checked="" type="checkbox"/>		
14 Any family history of cancers	<input checked="" type="checkbox"/>		
Do you take any regular medicines, or have you taken in the past?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	JENTIN MGT, ZEENAR 100
Do you smoke? If yes, what and how much each day?	<input checked="" type="checkbox"/>		
Do you drink alcohol? If yes, what is your average weekly intake?	<input checked="" type="checkbox"/>		
Have you ever taken elicited/recreational drugs?	<input checked="" type="checkbox"/>		
Are you doing regular sports or physical activities?	<input checked="" type="checkbox"/>		

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: 31/01/2023

Signature of Applicant:





Appendix 33: EX2 Form (Routine/Periodic Medical Examination)
**ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL –
CONFIDENTIAL)**

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. 110 70 mmhg	PULSE 83 /mins.	HEARING L N R N	VISION			Color Vision
175	108	35.3				DISTANT Uncorrected Corrected	NEAR R L R L		✓ 1. Normal 2. Abnormal
✓	1. Urinalysis	LABORATORY AND OTHER SPECIAL INVESTIGATIONS			N	A			
✓	2. Hb, Blood count, ESR						7. Audiogram		
✓	3. LFT, RFT, RBS						8. Lung Function		
	4. Drug Screen						9. Chest X-Ray		
✓	5. Lipids (40 years +)						10. ECG		
	6. Sickle Cell test						11. CVS risk for 40 yrs. & above 560		
OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.) Adv: DIET CONTROL / EXERCISE Life style modification & Regular treatment									
ASSESSMENT AND RECOMMENDATIONS: <input checked="" type="checkbox"/> FIT ALL AREAS <input type="checkbox"/> FIT WITH RESTRICTION <input type="checkbox"/> TEMPORARY UNFIT <input type="checkbox"/> UNFIT									
Date:	Name (Block Capitals): Dr. / Nurse			Signature:					
REVIEW/CONSULTATION  Dr. ABDUL RAHMAN MCH Licence No. 1421									
Date:	Name (Block Capitals): Dr. / Nurse			Signature:					