

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE
ISO 9001-2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

| | | | | |
|---|--|---|--|-------------|
| Mobile No: 94410472 | | Home/Leave Address: | Surname/Forenames: SHANI ANTHIL KADAM | |
| | | | LONALITY: INDIAN | |
| | | Company Number: 1722 | Reference Indicator: TRAUCY Oman | |
| Personal Details: Age-45, DOB-01/08/1976 Civil ID-111930799 | | | | |
| 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: 3 | |
| Reason for Examination (tick as appropriate) | | | | |
| Periodic Medical Examination <input checked="" type="checkbox"/> | | Final / Retirement <input type="checkbox"/> | Other Reason: <input type="checkbox"/> | |
| Employee only | | | | |
| B Present Job and Location: HEP / Almar Rima | | Next Job and Location: | | |
| Are you a registered person with special needs? <input type="checkbox"/> | | Do you belong to any Medical Insurance Scheme? <input type="checkbox"/> | | |
| 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 | <input checked="" type="checkbox"/> | | |
| 2 | Chest problems like asthma, bronchitis, other 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 | <input checked="" type="checkbox"/> | | |
| 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"/> | | | | |
| 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. | | | | |
| <p>DR. INNOCENT IFEANYI NWOKEDIUKO GENERAL PRACTITIONER RUSAYL HEALTH CENTRE MOBILE NO. 200821</p> | | <p>Signature of Applicant: </p> | | |
| <p>PC 124 RUSAYL Sultanate of Oman C.R. 112529514 Tel. 24382837 SAHARA PAC. NIMRA AC</p> <p></p> | | | | |

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 171 | WEIGHT kg 71 | BMI 24.3 | B.P. 120/80 | PULSE 60/mins. | HEARING L N R N | DISTANT Uncorrected 46 Corrected 46 | VISION R L 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 N/A | | | | | | 10. ECG | |
| ✓ | | 5. Lipids (40 years +) | | | | | | 11. CVS risk for 40 yrs. & above | |
| | | 6. Sickle Cell test N/A | | | | | | 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

DR. INNOCENT IFEANYI NWOKEDIUKO
GENERAL PRACTITIONER
RUSAYL HEALTH CENTRE
Name (Block Capitals) Dr. / Nurse

Date:

Signature:

REVIEW/CONSULTATION

Date:

Name (Block Capitals): Dr. / Nurse

Signature: