

1742

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS



الصحيه الرساليه
RUSAYL HEALTH CENTRE
NIMR, FAHUD, QARNALAH, BHAJA, SAHRIWAL, MARWAL

INITIAL EXAMINATION REPORT

Place of examination **Bahja** Date **1 / 1
23-3-19** Address **CN - 113039364**
Home Telephone number **98875752**

If a dependant or fiancee entr employees name jere :-

Surname :

Forenames:

		Nationality Indian	Country of birth India	Religion Hindu
<input checked="" type="checkbox"/> Male	<input type="checkbox"/> Single	<input type="checkbox"/> Widow(er)	Relationship to employee	
<input type="checkbox"/> Female	<input checked="" type="checkbox"/> Married	<input type="checkbox"/> Divorced Separated	<input checked="" type="checkbox"/> Wife	<input type="checkbox"/> Son <input checked="" type="checkbox"/> Daughter <input type="checkbox"/> Fiancee
Reason for examination PDO medical		Job :- mechanic	Area:- Isaima	
<input type="checkbox"/> Pre-employment				
<input type="checkbox"/> Pre-overseas				

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 (?) It ucerlain exclude minor ailmenis.)

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

How much tabacco each day ?

N A

Average daily alcohol consuption

N A

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

23-03-19

Signature of applicant

Rahul Patel

P.O Box : 18
C.C. 124, Rusayl

Sultanate of Oman



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

N - Normal A - Abnormal Please Describe	
N	A
f	1. Eyes & Pupils
c	2. E.N.T.
r	3. Teeth & Mouth
c	4. Lungs & Chest
r	5. Cardiovascular System
c	6. Abdo. Viscera
?	7. Hernial Orifices
c	8. Anus & Rectum
c	9. Genito - urinary
r	10. Extremities
r	11. Muscula-skeletal
r	12. Skin & Varicose Vns.
r	13. C.N.S.
r	14. Breasts
r	15.

PHYSICAL EXAMINATION

Bmi: 24.9 kg/m²

HEIGHT cm	WEIGHT kg	B.P. mmHg	HEARING L	HEARING R	VISION: Uncorrected	DISTANT R L	NEAR R L	COLOUR VISION	BLOOD GROUP
170	72	120/95	0 L	0 R	Corrected	0	0	0	

N	A	LABORATORY AND SPECIAL INVESTIGATIONS	N	A
r	1. Urimalysis			6. Audiogram
r	2. Hb Bloodcount ESR			7. Lung Function
r	3. Sarum Profile			8. Chest X-Ray
r	4. Stool			9. Drug Screen
r	5. E.C.G.			10. CR Screen

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

Bmi: Healthy wt.

ASSESSMENT

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

Date 25-03-19 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

