

1742

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS



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

INITIAL EXAMINATION REPORT

Surname Rahul Kumar Jabarbhai																																																																																																																																																																				
Forenames DOB - 11-9-81																																																																																																																																																																				
Address CN - 113039364																																																																																																																																																																				
Place of examination Bahja	Date 23-3-19																																																																																																																																																																			
Home Telephone number 98875754																																																																																																																																																																				
If a dependant or fancee entr employees name jere :-																																																																																																																																																																				
Surname : Forenames:																																																																																																																																																																				
Nationality Indians	Country of birth India																																																																																																																																																																			
Religion Hindu																																																																																																																																																																				
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Single <input type="checkbox"/> Widow(er) <input type="checkbox"/> Female <input checked="" type="checkbox"/> Married <input type="checkbox"/> Divorced Separated	Relationship to employee <input type="checkbox"/> Wife <input type="checkbox"/> Son <input checked="" type="checkbox"/> Daughter <input type="checkbox"/> Fiancee																																																																																																																																																																			
Reason for examination <input type="checkbox"/> Pre-employment <input type="checkbox"/> Pre-overseas	Job :- mechanic Area:- Haima																																																																																																																																																																			
Name and address of family doctor	List your last 3 jobs																																																																																																																																																																			
	(1)																																																																																																																																																																			
	(2)																																																																																																																																																																			
	(3)																																																																																																																																																																			
Are you Registered Disabled Person? (UK <input type="checkbox"/>)	Do you belong to any Medical Insurance Scheme? <input type="checkbox"/>																																																																																																																																																																			
DO YOU HAVE OR HAVE YOU HAD :- (Tick 'yes' or 'No' column or put a (?) If uncertain exclude minor ailments.)																																																																																																																																																																				
<table border="1"> <thead> <tr> <th></th> <th>Y</th> <th>N</th> </tr> </thead> <tbody> <tr><td>1. Sirius rouble</td><td></td><td></td></tr> <tr><td>2. Neck swellings/flands</td><td></td><td></td></tr> <tr><td>3. Difficulty in vision</td><td></td><td></td></tr> <tr><td>4. Any ear discharge</td><td></td><td></td></tr> <tr><td>5. Asthma/bronchitis</td><td></td><td></td></tr> <tr><td>6. Hayfever/other allergy</td><td></td><td></td></tr> <tr><td>7. Any skin trouble</td><td></td><td></td></tr> <tr><td>8. Tuberculosis</td><td></td><td></td></tr> <tr><td>9. Shortness of breath</td><td></td><td></td></tr> <tr><td>10. Coughed/vomited blood</td><td></td><td></td></tr> <tr><td>11. Severe abdominal pain</td><td></td><td></td></tr> <tr><td>12. Stomach ulcer</td><td></td><td></td></tr> <tr><td>13. Recurrent indigestion</td><td></td><td></td></tr> <tr><td>14. Jaundice or hepatitis</td><td></td><td></td></tr> <tr><td>15. Gall bladder disease</td><td></td><td></td></tr> <tr><td>16. Marked change in bowel habits</td><td></td><td></td></tr> <tr><td>17. Blood in stools (motions)</td><td></td><td></td></tr> <tr><td>18. Marked change in weight</td><td></td><td></td></tr> <tr><td>19. Varicose veins</td><td></td><td></td></tr> <tr><td>20. Lump in breast/armpit</td><td></td><td></td></tr> <tr><td>21. Cancer</td><td></td><td></td></tr> </tbody> </table>		Y	N	1. Sirius rouble			2. Neck swellings/flands			3. Difficulty in vision			4. Any ear discharge			5. Asthma/bronchitis			6. Hayfever/other allergy			7. Any skin trouble			8. Tuberculosis			9. Shortness of breath			10. Coughed/vomited blood			11. Severe abdominal pain			12. Stomach ulcer			13. Recurrent indigestion			14. Jaundice or hepatitis			15. Gall bladder disease			16. Marked change in bowel habits			17. Blood in stools (motions)			18. Marked change in weight			19. Varicose veins			20. Lump in breast/armpit			21. Cancer			<table border="1"> <thead> <tr> <th></th> <th>Y</th> <th>N</th> </tr> </thead> <tbody> <tr><td>22. Heart Disease</td><td></td><td></td></tr> <tr><td>23. Rheumatic Fever</td><td></td><td></td></tr> <tr><td>24. Abnormal heartbeat</td><td></td><td></td></tr> <tr><td>25. High blood pressure</td><td></td><td></td></tr> <tr><td>26. Stroke</td><td></td><td></td></tr> <tr><td>27. Serious chest pain</td><td></td><td></td></tr> <tr><td>28. Any blood disease</td><td></td><td></td></tr> <tr><td>29. Kidney disease</td><td></td><td></td></tr> <tr><td>30. Painful passage of urine</td><td></td><td></td></tr> <tr><td>31. Blood in urine</td><td></td><td></td></tr> <tr><td>32. Diabetes</td><td></td><td></td></tr> <tr><td>33. Headaches /migraine</td><td></td><td></td></tr> <tr><td>34. Dizziness/tainting</td><td></td><td></td></tr> <tr><td>35. Epilepsy</td><td></td><td></td></tr> <tr><td>36. Joints/spinal trouble</td><td></td><td></td></tr> <tr><td>37. Surgical operation</td><td></td><td></td></tr> <tr><td>38. Serious accident /tracture</td><td></td><td></td></tr> <tr><td>39. Tropical disease</td><td></td><td></td></tr> <tr><td>40. Fear of heights</td><td></td><td></td></tr> <tr><td>41. Rejected for employment or insurance for medical reasons</td><td></td><td></td></tr> </tbody> </table>		Y	N	22. Heart Disease			23. Rheumatic Fever			24. Abnormal heartbeat			25. High blood pressure			26. Stroke			27. Serious chest pain			28. Any blood disease			29. Kidney disease			30. Painful passage of urine			31. Blood in urine			32. Diabetes			33. Headaches /migraine			34. Dizziness/tainting			35. Epilepsy			36. Joints/spinal trouble			37. Surgical operation			38. Serious accident /tracture			39. Tropical disease			40. Fear of heights			41. Rejected for employment or insurance for medical reasons			<table border="1"> <thead> <tr> <th></th> <th>Y</th> <th>N</th> </tr> </thead> <tbody> <tr><td>42. Awarded benifities for Industrial injury/illness</td><td></td><td></td></tr> <tr><td>43. Treated for a mental condition. eg . depression</td><td></td><td></td></tr> <tr><td>44. Treated for problem drinking or drug abuse</td><td></td><td></td></tr> <tr><td>45. Exposed to toxic substance or noise</td><td></td><td></td></tr> <tr><td>FOR WOMEN ONLY</td><td></td><td></td></tr> <tr><td>Have you aver had:-</td><td></td><td></td></tr> <tr><td>46. An abnormal smear</td><td></td><td></td></tr> <tr><td>47. Any gynaecological treatment</td><td></td><td></td></tr> <tr><td>48. Are you pregnant?</td><td></td><td></td></tr> <tr><td>49. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE ?</td><td></td><td></td></tr> </tbody> </table>		Y	N	42. Awarded benifities for Industrial injury/illness			43. Treated for a mental condition. eg . depression			44. Treated for problem drinking or drug abuse			45. Exposed to toxic substance or noise			FOR WOMEN ONLY			Have you aver had:-			46. An abnormal smear			47. Any gynaecological treatment			48. Are you pregnant?			49. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE ?		
	Y	N																																																																																																																																																																		
1. Sirius rouble																																																																																																																																																																				
2. Neck swellings/flands																																																																																																																																																																				
3. Difficulty in vision																																																																																																																																																																				
4. Any ear discharge																																																																																																																																																																				
5. Asthma/bronchitis																																																																																																																																																																				
6. Hayfever/other allergy																																																																																																																																																																				
7. Any skin trouble																																																																																																																																																																				
8. Tuberculosis																																																																																																																																																																				
9. Shortness of breath																																																																																																																																																																				
10. Coughed/vomited blood																																																																																																																																																																				
11. Severe abdominal pain																																																																																																																																																																				
12. Stomach ulcer																																																																																																																																																																				
13. Recurrent indigestion																																																																																																																																																																				
14. Jaundice or hepatitis																																																																																																																																																																				
15. Gall bladder disease																																																																																																																																																																				
16. Marked change in bowel habits																																																																																																																																																																				
17. Blood in stools (motions)																																																																																																																																																																				
18. Marked change in weight																																																																																																																																																																				
19. Varicose veins																																																																																																																																																																				
20. Lump in breast/armpit																																																																																																																																																																				
21. Cancer																																																																																																																																																																				
	Y	N																																																																																																																																																																		
22. Heart Disease																																																																																																																																																																				
23. Rheumatic Fever																																																																																																																																																																				
24. Abnormal heartbeat																																																																																																																																																																				
25. High blood pressure																																																																																																																																																																				
26. Stroke																																																																																																																																																																				
27. Serious chest pain																																																																																																																																																																				
28. Any blood disease																																																																																																																																																																				
29. Kidney disease																																																																																																																																																																				
30. Painful passage of urine																																																																																																																																																																				
31. Blood in urine																																																																																																																																																																				
32. Diabetes																																																																																																																																																																				
33. Headaches /migraine																																																																																																																																																																				
34. Dizziness/tainting																																																																																																																																																																				
35. Epilepsy																																																																																																																																																																				
36. Joints/spinal trouble																																																																																																																																																																				
37. Surgical operation																																																																																																																																																																				
38. Serious accident /tracture																																																																																																																																																																				
39. Tropical disease																																																																																																																																																																				
40. Fear of heights																																																																																																																																																																				
41. Rejected for employment or insurance for medical reasons																																																																																																																																																																				
	Y	N																																																																																																																																																																		
42. Awarded benifities for Industrial injury/illness																																																																																																																																																																				
43. Treated for a mental condition. eg . depression																																																																																																																																																																				
44. Treated for problem drinking or drug abuse																																																																																																																																																																				
45. Exposed to toxic substance or noise																																																																																																																																																																				
FOR WOMEN ONLY																																																																																																																																																																				
Have you aver had:-																																																																																																																																																																				
46. An abnormal smear																																																																																																																																																																				
47. Any gynaecological treatment																																																																																																																																																																				
48. Are you pregnant?																																																																																																																																																																				
49. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE ?																																																																																																																																																																				
How much tabacco each day ? NA	Average daily alcohol consupction NA																																																																																																																																																																			
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"/> 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 23-03-19	Signature of applicant Rahul Kumar																																																																																																																																																																			



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	Bme: 24.9 kg/m ²							
		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. Muscula-skeletal								
		12. Skin & Varicose Vns.								
		13. C.N.S.								
		14. Breasts								
		15.								
HEIGHT cm	WEIGHT kg	B.P.	HEARING	HEARING	VISION:	DISTANT	NEAR	COLOUR VISION	BLOOD GROUP	
170	72	128/95 mmHg	L	L	Uncorrected	R	R			
			R	R	Corrected					
N	A	LABORATORY AND SPECIAL INVESTIGATIONS				N	A			
		1. Urinalysis							6. Audiogram	
		2. Hb Bloodcount ESR							7. Lung Function	
		3. Sarum Profile							8. Chest X-Ray	
		4. Stool							9. Drug Screen	
		5. E.C.G.							10. CR Screen	

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

Bme: Healthy wt.

ASSESSMENT

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

Date 25-03-19 Signature

DR. MOHAMMAD MARUF FERDOUS
MEDICAL OFFICER
RUSAYL HEALTH CENTRE
MOH LIC NO. 12930

Doctor / Sister

REVIEW/CONSULTATION

Date

Signature

Name (Block Capitals)

Doctor / Sister

