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مركز الرسيل الصحي

RUSAYL HEALTH CENTRE

ISO 9001- 2015 Certified Co.

No. B 09719

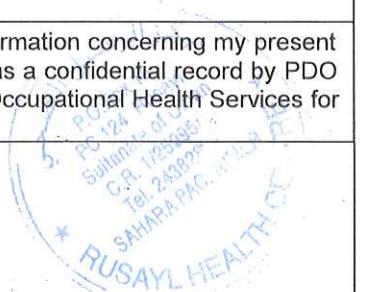
ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE

ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Mobile No. 79123228		Home/Leave Address: 1219	Surname/ Forenames Sathesh Kumar Parappottayil Panakrishna Pillai	
Personal Details 43y		Nationality Indian		Company Number: 1749 Reference Indicator: Tuckoman
A <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		<input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced <input type="checkbox"/> Widow(er)		
Home/Leave Address:		<input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter		No of Children: 01
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: Helper		Next Job and Location: NIV		
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			
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? <input type="checkbox"/>				
Do you smoke? If yes, what and how much each day? <input type="checkbox"/>				
Do you drink alcohol? If yes, what is your average weekly intake? <input type="checkbox"/>				
Have you ever taken elicited/recreational drugs? <input type="checkbox"/>				
Are you doing regular sports or physical activities? <input 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.				
27/09/2021		Signature of Applicant: Sathesh		
Date:		Signature of Applicant: Sathesh		
 <p>27/09/2021 Sathesh C.R. 123456 Tel: 2345678 SAHARA PARK, DUBAI RUSAYL HEALTH CENTRE</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							
<input checked="" type="checkbox"/>		1. Eyes & Pupils						
<input checked="" type="checkbox"/>		2. E.N.T.						
<input checked="" type="checkbox"/>		3. Teeth & Mouth						
<input checked="" type="checkbox"/>		4. Lungs & Chest						
<input checked="" type="checkbox"/>		5. Cardiovascular System						
<input checked="" type="checkbox"/>		6. Abdo. Viscera						
<input checked="" type="checkbox"/>		7. Hernial Orifices						
<input checked="" type="checkbox"/>		8. Anus & Rectum						
<input checked="" type="checkbox"/>		9. Genito-urinary						
<input checked="" type="checkbox"/>		10. Extremities						
<input checked="" type="checkbox"/>		11. Musculo-skeletal						
<input checked="" type="checkbox"/>		12. Skin & Varicose Vns.						
<input checked="" type="checkbox"/>		13. C.N.S.						
HEIGHT cm 161	WEIGHT kg 68	BMI 30.1	B.P. 126 85	PULSE 66/mins.	HEARING L Normal R Normal Uncorrected Corrected	DISTANT R 6/6	VISION NEAR R 6/6	
N	A			LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A		
<input checked="" type="checkbox"/>		1. Urinalysis		TG - 231			7. Audiogram	
<input checked="" type="checkbox"/>		2. Hb, Bloodcount, ESR		TG - 208			8. Lung Function	
<input checked="" type="checkbox"/>		3. LFT, RFT, RBS		LDL - 39.2			9. Chest X-Ray	
<input checked="" type="checkbox"/>		4. Drug Screen				<input checked="" type="checkbox"/>	10. ECG	
<input checked="" type="checkbox"/>		5. Lipids (40 years +)				<input checked="" type="checkbox"/>	11. CVS risk for 40 yrs. & above	
<input checked="" type="checkbox"/>		6. Sickle Cell test				<input checked="" type="checkbox"/>	12. HIV, Hepatitis screening	

OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)

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ASSESSMENT AND RECOMMENDATIONS:

FIT ALL AREAS FIT WITH RESTRICTION TEMPORARY UNFIT UNFIT

DR. SANATH BUDDHIKA PRIYADARSHAN

GENERAL PRACTITIONER
RUSAYL HEALTH CENTRE

MOULINO 16042

Date: Name (Block Capitals): Dr. / Nurse


Signature:

REVIEW/CONSULTATION

Date:

Name (Block Capitals): Dr. / Nurse

Signature: