#1748

FIW

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

مركز الرسيل الصحي
RUSAYL HEALTH CENTRE
SAHARA - PAC / RS - PAC
INITIAL EXAMINATION REPORT

RUSAYL HEALTH CENTRE P.O. Box 124, Rusayl Sultanate of Oman

| | |
|---|---|
| Surname | Kakkanat Padmalochanan |
| Forenames | Midhun |
| Address | Saudi Omani Medicals |
| Place of examination RHC | Date 10/12/17 |
| Home Telephone number | Age: 24yrs GSM: 79371532 |

ID: 1748

If a dependant or fancee entr employees name jere :-

Surname :

Forenames:

| Naticnality | Country of birth | Religion |
|---|---|---|
| Indian | India | Hindu |

| | | | |
|---|---|---|---|
| ☑ Male | ☑ Single | ☐ Widow(er) | |
| ☐ Female | ☐ Married | ☐ Divorced Separated | |

Relationship to employee: ☐ Wife ☐ Son ☐ Daughter ☐ Fiancee

Number of Children: —

Reason for examination: ☑ Pre-employment ☐ Pre-overseas

Job :- Safety Co-ordination

Area:- Desert

| 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 uncerlain exclude minor ailmenis.)

| | 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 | | ✗ |
| HAVE YOU EVER BEEN:- 41. Rejected for employment or insurance for medical reasons | | ✗ |

| | Y | N |
|---|---|---|
| 42. Awarded benifities for Industrial injury/lilness | | ✗ |
| 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 ? Nil

Average daily alcohol consuption Nil

Family history

Diabetes ✗ Tuberculosis ✗ Epilepsy ✗ Asthama ✗ Eczerna ✗

Heart disease ✗ High blood pressure ✓ Stroke ✗ Cancer ✗ Blood disease ✗

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 10/12/17

Signature of applicant Midhun

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 | |
| ✓ | | 2. E.N.T. | |
| ✓ | | 3. Teeth & Mouth | |
| ✓ | | 4. Lungs & Chest | |
| ✓ | | 5. Cardiovascular System | |
| ✓ | | 6. Abdo. Viscera | |
| ✓ | | 7. Hermial Orifices | |
| ✓ | | 8. Anus & Recturn | |
| ✓ | | 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 R / L | NEAR R / L | COLOUR VISION | BLOOD GROUP |
|---|---|---|---|---|---|---|---|---|---|
| 174cm | 58kg | 110/70 | L N R | L N R | Uncorrected | 6 / 6 | N/A | Nor | |
| | | | | | Corrected | 6 / 6 | | | |

| N | A | | LABORATORY AND SPECIAL INVESTIGATIONS | N | A | |
|---|---|---|---|---|---|---|
| ✓ | | 1. Urimalysis | RBS – 120 | | | 6. Audiogram |
| ✓ | | 2. Hb Bloodcount ESR | FBS – 108.23 mg/dl | | | 7. Lung Function |
| ✓ | | 3. Sarum Profile | | | | 8. Chest X-Ray |
| | | 4. Stool | Sickling test – negative | | | 9. Drug Screen |
| | | 5. E.C.G. | | | | 10. CR Screen |

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

**ASSESSMENT**

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

Date 18/12/2017 Signature [signature] Name (Block Capitals) DR. EVALYN T. DEOCAREZA Doctor / Sister

MEDICAL OFFICER
RUSAYL HEALTH CENTRE
MOH LIC NO. 10242

**REVIEW/CONSULTATION**

Date Signature Name (Block Capitals) Doctor / Sister