



مركز الرسيل الصحي RUSAYL HEALTH CENTRE

ISO 9001- 2015 Certified Co.

No. B17618

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE
ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Surname/Forenames **KHAMIS KHALFAN SAID AL JABRI**

Nationality **OMANI**

Mobile No. **97343377**

Home/Leave Address:

Company Number:

Reference Indicator:

Personal Details

Age - **32 yrs**, DOB - **21/04/1989**

A ☒ Male ☐ Female

☒ Married ☐ Single ☐ Separated /Divorced /Widow(er)

Home/Leave Address:

Relationship to employee

☐ Wife ☐ Son ☒ Daughter

No of Children: **3**

Reason for Examination (tick as appropriate)

Periodic Medical Examination ☒

Final / Retirement ☐

Other Reason: ☐

Employee only

B Present Job and Location:

Helper / marmul

Next Job and Location:

Truckman

Are you a registered person with special needs? ☐

Do you belong to any Medical Insurance Scheme? ☐

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 your taken in the past?			
Do you smoke? If yes, what and how much each day?			
Do you drink alcohol? If yes, what is your average weekly intake?			
Have you ever taken elicited/recreational drugs?			
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 .

Date:

03/10/22

Signature of Applicant:

[Signature]



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		WEIGHT kg		BMI	B.P.	PULSE	HEARING	VISION	
168		92		32.6	120 70	68/min.	LH RHL	DISTANT Uncorrected Corrected	NEAR Uncorrected Corrected
								R/L	R/L
N	A					LABORATORY AND OTHER SPECIAL INVESTIGATIONS		N	A
		1. Urinalysis				FRS-			7. Audiogram
		2. Hb, Bloodcount, ESR							8. Lung Function
		3. LFT, RFT, RBS							9. Chest X-Ray
		4. Drug Screen							10. ECG
		5. Lipids (40 years +)							11. CVS risk for 40 yrs. & above
		6. Sickie Cell test							12. HIV, Hepatitis screening
OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)									
ASSESSMENT AND RECOMMENDATIONS:									
<input type="checkbox"/> FIT ALL AREAS <input type="checkbox"/> FIT WITH RESTRICTION <input type="checkbox"/> TEMPORARY UNFIT <input type="checkbox"/> UNFIT									
Date: _____ Name (Block Capitals): Dr. / Nurse _____ Signature: _____									
REVIEW/CONSULTATION									
Date: _____ Name (Block Capitals): Dr. / Nurse _____ Signature: _____									