

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE
ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Mobile No. 99568159 Home/Leave Address: TRUCK OMAN		Surname/Forenames HARI LAL THACHI LETHIL
Personal Details DOB: 05/05/68		Nationality INDIAN (ID NO: 76213987) Company Number: Reference Indicator: ASH : 52 yrs
A <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		<input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced /Widow(er)
Home/Leave Address: Relationship to employee		<input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter No of Children: 2
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: PARK ALAM HELPER		Next Job and Location: P.O. Box: 18 P.C.: 124, Rusayl Sultanate of Oman
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		
		Description
Have you, since your last medical been treated by your family doctor or specialist for significant (major) ailments?		<input checked="" type="checkbox"/> N <input type="checkbox"/> Y
1	Ear, nose, eye or throat problems	<input checked="" type="checkbox"/> N <input type="checkbox"/> Y
2	Chest problems like asthma, bronchitis, other bad cough	<input checked="" type="checkbox"/> N <input type="checkbox"/> Y
3	Heart abnormality, chest pains	<input checked="" type="checkbox"/> N <input type="checkbox"/> Y
4	Abdominal pains, abnormal bowel motions	<input checked="" type="checkbox"/> N <input type="checkbox"/> Y
5	Urogenital problems (kidney disease, menstrual disorder)	<input checked="" type="checkbox"/> N <input type="checkbox"/> Y
6	Skin trouble or allergies	<input checked="" type="checkbox"/> N <input type="checkbox"/> Y
7	Epileptic fits, dizzy spells or migraine	<input checked="" type="checkbox"/> N <input type="checkbox"/> Y
8	History of mental illness, depression anxiety	<input checked="" type="checkbox"/> N <input type="checkbox"/> Y
9	Diabetes, thyroid disease	<input checked="" type="checkbox"/> N <input type="checkbox"/> Y
10	Blood disorder e.g. anaemia, blood cancer e.g. leukaemia	<input checked="" type="checkbox"/> N <input type="checkbox"/> Y
11	Any history of accidents or fractures	<input checked="" type="checkbox"/> N <input type="checkbox"/> Y
12	Have you had any serious allergies	<input checked="" type="checkbox"/> N <input type="checkbox"/> Y
13	Do any dependants have a significant ongoing illness?	<input checked="" type="checkbox"/> N <input type="checkbox"/> Y
14	Any family history of cancers	<input checked="" type="checkbox"/> N <input type="checkbox"/> Y
Do you take any regular medicines, or have you 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?		
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:	20/12/20	Signature of Applicant: <i>[Signature]</i>

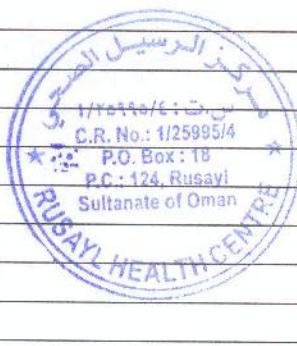
FOR COMPLETION BY EXAMINING DOCTOR OR NURSE

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.



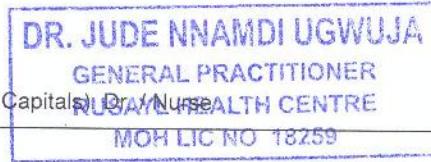
HEIGHT cm	WEIGHT kg	BMI	B.P.	PULSE /mins.	HEARING L R (W)	VISION	
						DISTANT R L	NEAR R L
165	72.4	26.6	137/86	57	Uncorrected Corrected	6/6 6/6	N/N Color vision (W)

N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A
		1. Urinalysis		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. Sickle Cell test		12. HIV, Hepatitis screening

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

ASSESSMENT AND RECOMMENDATIONS:

FIT ALL AREAS FIT WITH RESTRICTION TEMPORARY UNFIT UNFIT



Date: 25/12/20

Name (Block Capitals): Dr. / Nurse

Signature:

REVIEW/CONSULTATION

Date:

Name (Block Capitals): Dr. / Nurse

Signature: