



18990 Reg.Dt 10/12/2022

HARILAL THACHILEHL SUKUMARAN

 DUTINE/PERIODIC EXAMINATION REPORT (MEDICAL –
CONFIDENTIAL)

 1 Development Oman
AL DEPARTMENT

 PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

 Surname/
Forenames

 HARILAL THACHILEHL
SUKUMARAN

Nationality

INDIAN

DOB - 05/05/1968

Mobile No. 99563159 Address: 76213967 Company Number: 1227 Reference Indicator:

Personal Details

 A Male Female

 Married Single Separated /Divorced /Widow(er)

Home/Leave Address:

Relationship to employee

 Wife Son Daughter

No of Children: 2

Reason for Examination (tick as appropriate)

 Periodic Medical Examination

 Final / Retirement

 Other Reason:

Employee only

B Present Job and Location:

HELPER

Next Job and Location:

 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?		<input checked="" type="checkbox"/>	
1	Ear, nose, eye or throat problems		<input checked="" type="checkbox"/>	
2	Chest problems like asthma, bronchitis, another bad cough		<input checked="" type="checkbox"/>	
3	Heart abnormality, chest pains		<input checked="" type="checkbox"/>	
4	Abdominal pains, abnormal bowel motions		<input checked="" type="checkbox"/>	
5	Urogenital problems (kidney disease, menstrual disorder)		<input checked="" type="checkbox"/>	
6	Skin trouble or allergies		<input checked="" type="checkbox"/>	
7	Epileptic fits, dizzy spells or migraine		<input checked="" type="checkbox"/>	
8	History of mental illness, depression anxiety		<input checked="" type="checkbox"/>	
9	Diabetes, thyroid disease, history of Hypertension		<input checked="" type="checkbox"/>	
10	Blood disorder e.g. anaemia, blood cancer e.g. leukaemia		<input checked="" type="checkbox"/>	
11	Any history of accidents or fractures		<input checked="" type="checkbox"/>	BIKE ACCIDENT 1 YEAR AGO
12	Have you had any serious allergies		<input checked="" type="checkbox"/>	
13	Do any dependants have a significant ongoing illness?		<input checked="" type="checkbox"/>	
14	Any family history of cancers		<input checked="" type="checkbox"/>	
	Do you take any regular medicines, or have you taken in the past?		<input checked="" type="checkbox"/>	
	Do you smoke? If yes, what and how much each day?		<input checked="" type="checkbox"/>	
	Do you drink alcohol? If yes, what is your average weekly intake?		<input checked="" type="checkbox"/>	
	Have you ever taken elicited/recreational drugs?		<input checked="" type="checkbox"/>	
	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: 10/12/2022

Signature of Applicant:



ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)



FOR COMPLETION BY EXAMINING DOCTOR OR NURSE

Further details of medical history and recreational activities

				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. 130 90 mmhg	PULSE 60/mins.	HEARING L ✓ R ✓	VISION DISTANT NEAR R L R L Uncorrected 6/6 Corrected 6/6			Color Vision ✓ 1. Normal 2. Abnormal
N	A			LABORATORY AND OTHER SPECIAL INVESTIGATIONS			N	A		
✓		1. Urinalysis					✓		7. Audiogram	
✓		2. Hb, Blood count, ESR							8. Lung Function	
✓		3. LFT, RFT, RBS							9. Chest X-Ray	
✓		4. Drug Screen					✓		10. ECG	
✓		5. Lipids (40 years +)					11.2		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

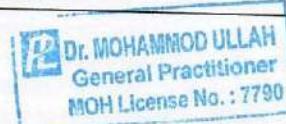
Date: Name (Block Capitals): Dr. / Nurse

Signature:



REVIEW/CONSULTATION

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



Signature: