



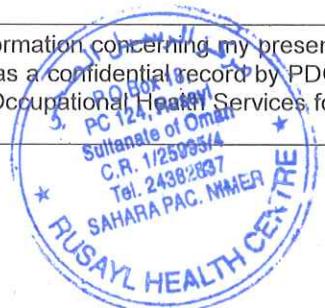
ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



**RUSAYL HEALTH CENTRE**  
ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

<b>Personal Details</b> Mobile No: <u>95246762</u> Home/Leave Address: <u>Madra</u>		Surname/Forenames <u>Redha khalifa</u> Nationality <u>Mohammed Al Saidi</u> Omani Company Number: <u>10325</u> Reference Indicator: <u>Trukhman</u>	
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:			
<b>Reason for Examination</b> (tick as appropriate) <input type="checkbox"/> Periodic Medical Examination <input checked="" type="checkbox"/> Final / Retirement <input type="checkbox"/> Other Reason: <input type="checkbox"/>			
<b>Employee only</b>			
B Present Job and Location: <u>HD</u>		Next Job and Location: <u>NIM</u>	
Are you a registered person with special needs? <input type="checkbox"/>		Do you belong to any Medical Insurance Scheme? <input type="checkbox"/>	
<b>Previous Medical History:</b> 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.			
<b>Please answer the following questions and tick 'N' (no) or 'Y' (yes) in the column. If 'Y' Please describe</b>			
		N	Y
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	<b>Have you had any serious allergies</b>		
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?			
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?			
<b>STATEMENT:</b> 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.			
<u>21/02/2022</u>			
Date:		Signature of Applicant:	



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. mm Hg	PULSE b/mins.	HEARING L R	VISION DISTANT R L	VISION NEAR R L		
170	79	27	110 80	82	Normal Normal Uncorrected Corrected	6/6	6/6		
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.)

Advised on戒煙 reduction.

ASSESSMENT AND RECOMMENDATIONS:

FIT ALL AREAS  FIT WITH RESTRICTION  TEMPORARY UNFIT  UNFIT

DR. SANATH BUDDHIKA PRYADARSHAN  
GENERAL PRACTITIONER  
RUSAYL HEALTH CENTRE  
MOH LIC NO. 16042

21/02/2022

Date:

Name (Block Capitals): Dr. / Nurse

Signature:

REVIEW/CONSULTATION

Date:

Name (Block Capitals): Dr. / Nurse

Signature:

