

#1566

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS



مركز الرعاية الصحية  
RUSAYL HEALTH CENTRE  
NIMR, FAHUD, QARNALAM, BHAJA, SAHRIWAL, MARJUL

## INITIAL EXAMINATION REPORT

Surname <u>Pearul Islam</u>																																																																																																																																																																							
Forenames <u>DOB - 3.4.82</u> , <u>EN - 105604274</u>																																																																																																																																																																							
Address <u>Truck - Oman , Haima</u>																																																																																																																																																																							
Place of examination <u>Bahja</u>	Date <u>10.03.19</u>																																																																																																																																																																						
Home Telephone number <u>94462856</u>																																																																																																																																																																							
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Surname : Forenames:																																																																																																																																																																							
Naticality <u>Bangladeshi</u>	Country of birth <u>Bangladesh</u> Religion <u>Islam</u>																																																																																																																																																																						
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Single <input type="checkbox"/> Widow(er) <input type="checkbox"/> Female <input checked="" type="checkbox"/> Married <input type="checkbox"/> Divorced Separated	Relationship to employee <input checked="" type="checkbox"/> Wife <input checked="" type="checkbox"/> Son <input checked="" type="checkbox"/> Daughter <input type="checkbox"/> Fiancee																																																																																																																																																																						
Number of Children <u>4</u>																																																																																																																																																																							
Reason for examination <input type="checkbox"/> Pre-employment <input checked="" type="checkbox"/> Job :- <u>Rigger</u>	Area:- <u>Haima</u>																																																																																																																																																																						
Pre-overseas																																																																																																																																																																							
Name and address of family doctor	List your last 3 jobs																																																																																																																																																																						
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Are you Registered Disabled Person? (UK) <input type="checkbox"/>	Do you belong to any Medical Insurance Scheme? <input type="checkbox"/>																																																																																																																																																																						
DO YOU HAVE OR HAVE YOU HAD :- (Tick 'yes' or 'No' column or put a (?) If uncertain exclude minor ailments.)																																																																																																																																																																							
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Family history	Diabetes <input checked="" type="checkbox"/> Tuberculosis <input checked="" type="checkbox"/> Epilepsy <input checked="" type="checkbox"/> Asthma <input checked="" type="checkbox"/> Heart disease <input checked="" type="checkbox"/> High blood pressure <input checked="" type="checkbox"/> Stroke <input checked="" type="checkbox"/> Eczerna <input checked="" type="checkbox"/> Cancer <input checked="" type="checkbox"/> Blood disease <input checked="" type="checkbox"/>																																																																																																																																																																						
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 <u>10.3.19</u>	Signature of applicant <u>PEARUL</u>																																																																																																																																																																						



FOR COMPLETION BY EXAMINING DOCTOR OR SISTER  
FURTHER DETAILS OF MEDICAL HISTORY AND RECREATIONAL ACTIVITIES

LABORATORY INVESTIGATION

N - Normal A - Abnormal Please Describe		PHYSICAL EXAMINATION								
N	A	1. Eyes & Pupils	<p>BMI: 25.8 kg/cm<sup>2</sup></p>							
		2. E.N.T.								
		3. Teeth & Mouth								
		4. Lungs & Chest								
		5. Cardiovascular System								
		6. Abdo. Viscera								
		7. Hermial Orifices								
		8. Anus & Rectum								
		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 L	HEARING R	VISION: Uncorrected	DISTANT R L	NEAR R L	COLOUR VISION	BLOOD GROUP	
166	11	116/68 mmHg	L	R	Corrected			2.		

N	A	LABORATORY AND SPECIAL INVESTIGATIONS		N	A
		1. Urinalysis			
		2. Hb Bloodcount ESR			6. Audiogram
		3. Sarum Profile			7. Lung Function
		4. Stool			8. Chest X-Ray
		5. E.C.G.			9. Drug Screen
					10. CR Screen

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

BMI: Overweight

do regular physical exercise  
avoid extra calories and fatty foods.

ASSESSMENT

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

Date 11-03-19 Signature

DR. MOHAMMAD MARUF FERDOUS  
MEDICAL OFFICER  
RUSAYL HEALTH CENTRE  
MOR LIC NO: 12930

Doctor / Sister

REVIEW/CONSULTATION

Date Signature

Name (Block Capitals)

Doctor / Sister

