

DOB  
01/01/1981  
UNL-151474  
RHC

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

#10329

مكتب المعايل الصحي  
RUSAYL HEALTH CENTRE  
SAHARA - PAC / RS - PAC

INITIAL EXAMINATION REPORT

Place of examination Date 10/04/19  
RS PAC CLINIC BAHJA

Surname HENDI KHAMES AL QUTAITI	
Forenames HENDI	
Address TRUKOMAN	
Staff - 10329	
Home Telephone number 968714413	

If a dependant or fiancee entr employees name jere :-

Surname :

Forenames:

Nationality OMAN			Country of birth OMAN	Religion ISLAM
<input checked="" type="checkbox"/> Male	<input checked="" type="checkbox"/> Single	<input checked="" type="checkbox"/> Widow(er)	Relationship to employee	
<input type="checkbox"/> Female	<input type="checkbox"/> Married	<input checked="" type="checkbox"/> Divorced Separated	<input type="checkbox"/> Wife	<input type="checkbox"/> Son
			<input type="checkbox"/> Daughter	<input type="checkbox"/> Fiancee

Reason for examination  Pre-employment Job :- OPERATOR  
 Pre-overseas Area:- BAHJA

Name and address of family doctor

List your last 3 jobs

(1)

(2)

(3)

Are you Registered Disabled Person? (UK)

Do you belong to any Medical Insurance Scheme?

DO YOU HAVE OR HAVE YOU HAD :- (Tick "yes" or "No" column or put a (?) If uncertain exclude minor ailments.)

	Y	N		Y	N		Y	N
1. Sirius rouble		<input checked="" type="checkbox"/>	22. Heart Disease		<input checked="" type="checkbox"/>	42. Awarded benefits for Industrial injury/illness		<input checked="" type="checkbox"/>
2. Neck swellings/lands		<input checked="" type="checkbox"/>	23. Rheumatic Fever		<input checked="" type="checkbox"/>	43. Treated for a mental condition. eg . depression		<input checked="" type="checkbox"/>
3. Difficulty in vision		<input checked="" type="checkbox"/>	24. Abnormal heartbeat		<input checked="" type="checkbox"/>	44. Treated for problem drinking or drug abuse		<input checked="" type="checkbox"/>
4. Any ear discharge		<input checked="" type="checkbox"/>	25. High blood pressure		<input checked="" type="checkbox"/>	45. Exposed to toxic substance or noise		<input checked="" type="checkbox"/>
5. Asthma/bronchitis		<input checked="" type="checkbox"/>	26. Stroke		<input checked="" type="checkbox"/>	FOR WOMEN ONLY		
6. Hayfever/other allergy		<input checked="" type="checkbox"/>	27. Serious chest pain		<input checked="" type="checkbox"/>	Have you ever had:-		
7. Any skin trouble		<input checked="" type="checkbox"/>	28. Any blood disease		<input checked="" type="checkbox"/>	46. An abnormal smear		
8. Tuberculosis		<input checked="" type="checkbox"/>	29. Kidney disease		<input checked="" type="checkbox"/>	47. Any gynaecological treatment		
9. Shortness of breath		<input checked="" type="checkbox"/>	30. Painful passage of urine		<input checked="" type="checkbox"/>	48. Are you pregnant?		
10. Coughed/vomited blood		<input checked="" type="checkbox"/>	31. Blood in urine		<input checked="" type="checkbox"/>	49. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE ?		
11. Severe abdominal pain		<input checked="" type="checkbox"/>	32. Diabetes		<input checked="" type="checkbox"/>			
12. Stomach ulcer		<input checked="" type="checkbox"/>	33. Headaches /migraine		<input checked="" type="checkbox"/>			
13. Recurrent indigestion		<input checked="" type="checkbox"/>	34. Dizziness/tainting		<input checked="" type="checkbox"/>			
14. Jaundice or hepatitis		<input checked="" type="checkbox"/>	35. Epilepsy		<input checked="" type="checkbox"/>			
15. Gall bladder disease		<input checked="" type="checkbox"/>	36. Joints/spinal trouble		<input checked="" type="checkbox"/>			
16. Marked change in bowel habits		<input checked="" type="checkbox"/>	37. Surgical operation		<input checked="" type="checkbox"/>			
17. Blood in stools (motions)		<input checked="" type="checkbox"/>	38. Serious accident /fracture		<input checked="" type="checkbox"/>			
18. Marked change in weight		<input checked="" type="checkbox"/>	39. Tropical disease		<input checked="" type="checkbox"/>			
19. Varicose veins		<input checked="" type="checkbox"/>	40. Fear of heights		<input checked="" type="checkbox"/>			
20. Lump in breast/armpit		<input checked="" type="checkbox"/>	HAVE YOU EVER BEEN:-		<input checked="" type="checkbox"/>			
21. Cancer		<input checked="" type="checkbox"/>	41. Rejected for employment or insurance for medical reasons		<input checked="" type="checkbox"/>			

How much tabacco each day ? 1-2

Average daily alcohol consuption

Family history	<input checked="" type="checkbox"/> Diabetes	<input checked="" type="checkbox"/> Tuberculosis	<input checked="" type="checkbox"/> Epilepsy	<input checked="" type="checkbox"/> Asthma	<input checked="" type="checkbox"/> Eczema
	<input checked="" type="checkbox"/> Heart disease	<input checked="" type="checkbox"/> High blood pressure	<input checked="" type="checkbox"/> Stroke	<input checked="" type="checkbox"/> Cancer	<input checked="" type="checkbox"/> Blood disease

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 10/04/19

Signature of applicant

FOR COMPLETION BY EXAMINING DOCTOR OR SISTER  
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. Muscula-skeletal
✓	12. Skin & Varicose Vns.
✓	13. C.N.S.
✓	14. Breasts
	15.

BMI - 30.0 kg/m<sup>2</sup>  
HR - 82 bpm



HEIGHT cm	WEIGHT kg	B.P.	HEARING L	HEARING R	VISION: Uncorrected	DISTANT R   L	NEAR R   L	COLOUR VISION	BLOOD GROUP
172	88.7	131/81	(1)	(1)					

N	A	LABORATORY AND SPECIAL INVESTIGATIONS	N	A
✓	1. Urinalysis	TC - 239 mg/dl		6. Audiogram
✓	2. Hb Bloodcount ESR	hdl - 37.62 mg/dl		7. Lung Function
✓	3. Serum Profile	hdl - 114.5 mg/dl		8. Chest X-Ray
✓	4. Stool			9. Drug Screen
	5. E.C.G.			10. CR Screen

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

BMI - 30.0 kg/m<sup>2</sup>

AN

- ✓ Regular exercise
- ✓ Weight reduction
- ✓ Take plenty of fruits, vegetables & fish oil

ASSESSMENT

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

Date 11.04.19

  
Signature

Doctor / Sister

REVIEW/CONSULTATION

**DR. HASAN MAHBUB KHAN BAYZID**  
Name (Block Capitals)  
**MEDICAL OFFICER**  
**RUSAYL HEALTH CENTRE**  
**MOH LIC NO. 15691**

Date

Signature

Name (Block Capitals)

Doctor / Sister