



PEACE LAND MEDICAL CENTER



MEDICAL EXAMINATION REPORT (CONFIDENTIAL)

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Surname	MOHAMED KHALIL
Forenames	WASUNULLAH MOHAMED
Address	115838474 - TRUCK OMAN
Home telephone number	95198187

SLB

Place of examination : MUSCAT	Date : 1/11/2022				
If a dependant enter employee's name here:					
Surname:	Forenames:				
Birth date: 2/3/70	Nationality: INDIAN				
Country of birth: INDIA	Religion: MUSLIM				
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated / Divorced				
Relationship to employee					
<input type="checkbox"/> Wife <input checked="" type="checkbox"/> Son <input type="checkbox"/> Daughter	Number of children: 4				
Reason for examination	Pre-Employment <input type="checkbox"/> Periodic medical check-up <input checked="" type="checkbox"/> Job: H.D.D				
Pre-Overseas <input type="checkbox"/>	Area:				
Name and address of family doctor	List your last 3 jobs				
	(1)				
	(2)				
	(3)				
Are you a Registered Disabled Person? (UK only) <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.)					
Y	N	Y	N	Y	N
1. Sinus trouble		21. Cancer		HAVE YOU EVER BEEN:-	
2. Neck swelling/glands		22. Heart Disease		41. Rejected for employment or insurance for medical reasons	
3. Difficulty in vision		23. Rheumatic fever		42. Awarded benefits for industrial injury/illness	
4. Any ear discharge		24. Abnormal heartbeat		43. Treated for a mental condition, e.g. depression	
5. Asthma/bronchitis		25. High blood pressure	<input checked="" type="checkbox"/>	44. Treated for problem drinking or drug abuse	
6. Hayfever /other significant allergy		26. Stroke		45. Exposed to toxic substance or noise	
7. Any skin trouble		27. Serious chest pain		FOR WOMEN ONLY	
8. Tuberculosis		28. Any blood disease		Have you ever had:-	
9. Shortness of breath		29. Kidney disease		46. An abnormal smear	
10. Coughed/vomited blood		30. Blood in urine		47. Any gynaecological treatment	
11. Severe abdominal pain		31. Painful passage of urine		48. Are you pregnant?	
12. Stomach ulcer		32. Diabetes	<input checked="" type="checkbox"/>	49. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE	
13. Recurrent indigestion		33. Headaches/migraine			
14. Jaundice or hepatitis		34. Dizziness/fainting			
15. Gall Bladder disease		35. Epilepsy			
16. Marked change in bowel habits		36. Joints/spinal trouble			
17. Blood in stools (motions)		37. Surgical operation			
18. Marked change in weight		38. Serious accident/fracture			
19. Varicose veins		39. Tropical disease			
20. Lump in breast/armpit		40. Fear of heights			
How much tobacco each day? NO	Average daily alcohol consumption NO				
Have you ever taken elicited drugs? ()					
FAMILY HISTORY: Diabetes () Tuberculosis () Epilepsy () Asthma () Eczema ()					
Heart disease () High blood pressure () Stroke () Blood Disease () Cancer ()					
PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT:-					
I declared these statements to be true to the best of my knowledge and belief and I agree that the result of this medical examination 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: 1/11/2022			Signature of Applicant: [Signature]		

DM & ATN on medication
T. Colophage 500 mg



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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	
<input checked="" type="checkbox"/>		1. Eyes & Pupils
<input checked="" type="checkbox"/>		2. E.N.T.
<input checked="" type="checkbox"/>		3. Teeth & Mouth
<input checked="" type="checkbox"/>		4. Lungs & Chest
<input checked="" type="checkbox"/>		5. Cardiovascular System
<input checked="" type="checkbox"/>		6. Abdo. Viscera
<input checked="" type="checkbox"/>		7. Hernial Orifices
<input checked="" type="checkbox"/>		8. Anus & Rectum
<input checked="" type="checkbox"/>		9. Genito-urinary
<input checked="" type="checkbox"/>		10. Extremities
<input checked="" type="checkbox"/>		11. Musculo-skeletal
<input checked="" type="checkbox"/>		12. Skin & Varicose Vns.
<input checked="" type="checkbox"/>		13. C.N.S.
<input checked="" type="checkbox"/>		14. Breast

HEIGHT cm	WEIGHT kg	BMI	B.P.	PULSE	HEARING	VISION	Colour Vision	Blood Group
162	83	31.6	140/90	70 /mins.	L N R N	DISTANT R L Uncorrected 6/6 Corrected 6/6	N	

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 +)		25.3		11. CVS risk for 40 yrs. & above	
✓		6. Sickie Cell test				12. HIV, Hepatitis screening	

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

1. Regular Fm by internist & cardiologist
2. LSM & RFR (Lwt, Exercise & diet)

ASSESSMENT:

☒ FIT ALL AREAS ☐ FIT WITH RESTRICTION ☐ TEMPORARY UNFIT ☐ UNFIT

Date: 2, 11, 22 Name (Block Capitals): Dr. / Nurse

Dr. Shima Sedadollah Jafar
Cardiologist Specialist
MOH Lic. No. 21962

Signature:

REVIEW/CONSULTATION

Date:

Name (Block Capitals): Dr. / Nurse

Signature: