



TMT



PEACE LAND MEDICAL CENTER

MEDICAL EXAMINATION REPORT (CONFIDENTIAL)

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Surname: MOHAMED IKHIL
 Forenames: WA SULLAH 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: INDIA	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: 2
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	
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 <input type="checkbox"/>
3. Difficulty in vision			23. Rheumatic fever			42. Awarded benefits for industrial injury/illness <input type="checkbox"/>
4. Any ear discharge			24. Abnormal heartbeat			43. Treated for a mental condition, e.g. depression <input type="checkbox"/>
5. Asthma/bronchitis			25. High blood pressure	<input checked="" type="checkbox"/>		44. Treated for problem drinking or drug abuse <input type="checkbox"/>
6. Hayfever /other significant allergy			26. Stroke			45. Exposed to toxic substance or noise <input type="checkbox"/>
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 <input type="checkbox"/>
10. Coughed/vomited blood			30. Blood in urine			47. Any gynaecological treatment <input type="checkbox"/>
11. Severe abdominal pain			31. Painful passage of urine			48. Are you pregnant? <input type="checkbox"/>
12. Stomach ulcer			32. Diabetes	<input checked="" type="checkbox"/>		49. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE <input type="checkbox"/>
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? Average daily alcohol consumption 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

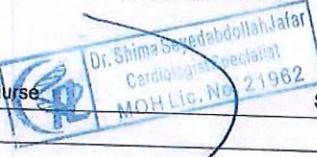
Signature of Applicant:

DM & HTN on medication
T colchophate 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												
✓	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.												
	14. Breast												
HEIGHT cm	WEIGHT kg	BMI	B.P.	PULSE /mins.	HEARING L R	VISION DISTANT R L					Colour Vision	Blood Group	
162	83	31.6	140 90	70	N	Uncorrected	Corrected	6/6	5/6	R L	~		
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS					N	A					
✓	1. Urinalysis						✓						
✓	2. Hb, Bloodcount, ESR						✓						
✓	3. LFT, RFT, RBS						✓						
✓	4. Drug Screen						✓						
✓	5. Lipids (40 years +)						✓						
✓	6. Sickle Cell test						✓						
OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)													
1. Regular F/U by internist & cardiologist Due Hx of DM on med 2. LSM & RFR (Fwt, Exercise & diet) Due Hx of HTN on med													
ASSESSMENT:													
<input checked="" type="checkbox"/> FIT ALL AREAS <input type="checkbox"/> FIT WITH RESTRICTION <input type="checkbox"/> TEMPORARY UNFIT				<input type="checkbox"/> UNFIT									
Date: 2/11/22 Name (Block Capitals): Dr. / Nurse				 Signature:									
REVIEW/CONSULTATION													
Date: _____ Name (Block Capitals): Dr. / Nurse				Signature: _____									