

**ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)**



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

PLEASE COMPLETE YOUR PERSONAL  
DETAILS IN BLOCK CAPITALS

|                       |                                        |
|-----------------------|----------------------------------------|
| Surname/<br>Forenames | Salim Mohammed<br>Hamed Said Al Maharb |
| Nationality           | Oman                                   |
| Company Number:       | 10347                                  |
| Reference Indicator:  | Track Oman                             |

|           |          |                    |          |
|-----------|----------|--------------------|----------|
| Mobile No | 97760779 | Home/Leave Address | Munshabi |
|-----------|----------|--------------------|----------|

|                  |                                          |
|------------------|------------------------------------------|
| Personal Details | SSY / DOB - 29, 04, 1988 / ID - 20413811 |
|------------------|------------------------------------------|

|                                                                            |                                                                                                                                       |
|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|
| 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                                                                     | No of Children: |
|                     | <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter |                 |

Reason for Examination (tick as appropriate)

|                                                                  |                                             |                                        |
|------------------------------------------------------------------|---------------------------------------------|----------------------------------------|
| Periodic Medical Examination <input checked="" type="checkbox"/> | Final / Retirement <input type="checkbox"/> | Other Reason: <input type="checkbox"/> |
|------------------------------------------------------------------|---------------------------------------------|----------------------------------------|

**Employee only**

|                             |                        |
|-----------------------------|------------------------|
| B Present Job and Location: | Next Job and Location: |
| F.L. Operator               | NIMV                   |

|                                                                          |                                                                         |
|--------------------------------------------------------------------------|-------------------------------------------------------------------------|
| Are you a registered person with special needs? <input type="checkbox"/> | Do you belong to any Medical Insurance Scheme? <input type="checkbox"/> |
|--------------------------------------------------------------------------|-------------------------------------------------------------------------|

**Previous Medical History:** 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.

**Please answer the following questions and tick 'N' (no) or 'Y' (yes) in the column. If 'Y' Please describe**

|                                                                                                                      | N | Y | Description |
|----------------------------------------------------------------------------------------------------------------------|---|---|-------------|
| 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 Have you had any serious allergies                                                                                |   |   |             |
| 13 Do any dependants have a significant ongoing illness?                                                             |   |   |             |
| 14 Any family history of cancers                                                                                     |   |   |             |
| Do you take any regular medicines, or have your 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?                                                                 |   |   |             |

**STATEMENT:** 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 .

|                  |                                                                                                             |
|------------------|-------------------------------------------------------------------------------------------------------------|
| Date: 03/04/2023 | Signature of Applicant:  |
|------------------|-------------------------------------------------------------------------------------------------------------|



# مرکز الرسيل الصحي RUSAYL HEALTH CENTRE

ISO 9001 - 2015 Certified Co.

No. B 13898

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<br>cm | WEIGHT<br>kg | BMI | B.P.   | PULSE    | HEARING              | VISION                            |
|--------------|--------------|-----|--------|----------|----------------------|-----------------------------------|
| 158          | 64           | 25  | 122/80 | 66 mins. | L Normal<br>R Normal | DISTANT<br>R 6/6<br>NEAR<br>R 6/6 |

| N | A |                        | LABORATORY AND OTHER<br>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. Sickie Cell test    |                                                |   |   | 12. HIV, Hepatitis screening     |

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

Advised on 100% fat diet, 100% protein  
FCP after 06 months.

## ASSESSMENT AND RECOMMENDATIONS:

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

Date: 03/04/2023 Name (Block Capitals): Dr. / Nurse

Signature:

## REVIEW/CONSULTATION

Date: Name (Block Capitals): Dr. / Nurse

Signature: