

#1806

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS



مركز الرعاية الصحية
RUSAYL HEALTH CENTRE
NIMR, FAHUD, QARNALAW, BHAJA, SAHRIWAL, WARXUL

INITIAL EXAMINATION REPORT

Surname Romjan Matabber																																																																																																																																					
Forenames DOB - 20-4-92, CN - 46132835																																																																																																																																					
Address Truck-man, Haina																																																																																																																																					
Place of examination Bahja	Date 12-03-19																																																																																																																																				
Home Telephone number 94957496																																																																																																																																					
If a dependant or fancee entr employees name jere :-																																																																																																																																					
Surname : Forenames:																																																																																																																																					
Naticality Bangladeshi	Country of birth Bangladesh Religion Islam																																																																																																																																				
<input checked="" type="checkbox"/> Male <input checked="" type="checkbox"/> Single <input type="checkbox"/> Widow(er) <input type="checkbox"/> Female <input type="checkbox"/> Married <input type="checkbox"/> Divorced Separated	Relationship to employee <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Fiancee Number of Children -																																																																																																																																				
Reason for examination <input type="checkbox"/> Pre-employment <input type="checkbox"/> Pre-overseas	Job :- Rigger Area:- Haina																																																																																																																																				
Name and address of family doctor	List your last 3 jobs																																																																																																																																				
	(1)																																																																																																																																				
	(2)																																																																																																																																				
	(3)																																																																																																																																				
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.)																																																																																																																																					
<table border="1"> <thead> <tr> <th></th> <th>Y</th> <th>N</th> </tr> </thead> <tbody> <tr><td>1. Sirius rouble</td><td></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>2. Neck swellings/flands</td><td></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>3. Difficulty in vision</td><td></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>4. Any ear discharge</td><td></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>5. Asthma/bronchitis</td><td></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>6. Hayfever/other allergy</td><td></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>7. Any skin trouble</td><td></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>8. Tuberculosis</td><td></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>9. Shortness of breath</td><td></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>10. Coughed/vomited blood</td><td></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>11. Severe abdominal pain</td><td></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>12. Stomach ulcer</td><td></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>13. Recurrent indigestion</td><td></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>14. Jaundice or hepatitis</td><td></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>15. Gall bladder disease</td><td></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>16. Marked change in bowel habits</td><td></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>17. Blood in stools (motions)</td><td></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>18. Marked change in weight</td><td></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>19. Varicose veins</td><td></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>20. Lump in breast/armpit</td><td></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>21. Cancer</td><td></td><td><input checked="" type="checkbox"/></td></tr> </tbody> </table>		Y	N	1. Sirius rouble		<input checked="" type="checkbox"/>	2. Neck swellings/flands		<input checked="" type="checkbox"/>	3. Difficulty in vision		<input checked="" type="checkbox"/>	4. Any ear discharge		<input checked="" type="checkbox"/>	5. Asthma/bronchitis		<input checked="" type="checkbox"/>	6. Hayfever/other allergy		<input checked="" type="checkbox"/>	7. Any skin trouble		<input checked="" type="checkbox"/>	8. Tuberculosis		<input checked="" type="checkbox"/>	9. Shortness of breath		<input checked="" type="checkbox"/>	10. Coughed/vomited blood		<input checked="" type="checkbox"/>	11. Severe abdominal pain		<input checked="" type="checkbox"/>	12. Stomach ulcer		<input checked="" type="checkbox"/>	13. Recurrent indigestion		<input checked="" type="checkbox"/>	14. Jaundice or hepatitis		<input checked="" type="checkbox"/>	15. Gall bladder disease		<input checked="" type="checkbox"/>	16. Marked change in bowel habits		<input checked="" type="checkbox"/>	17. Blood in stools (motions)		<input checked="" type="checkbox"/>	18. Marked change in weight		<input checked="" type="checkbox"/>	19. Varicose veins		<input checked="" type="checkbox"/>	20. Lump in breast/armpit		<input checked="" type="checkbox"/>	21. Cancer		<input checked="" type="checkbox"/>	<table border="1"> <thead> <tr> <th></th> <th>Y</th> <th>N</th> </tr> </thead> <tbody> <tr><td>22. Heart Disease</td><td></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>23. Rheumatic Fever</td><td></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>24. Abnormal heartbeat</td><td></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>25. High blood pressure</td><td></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>26. Stroke</td><td></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>27. Serious chest pain</td><td></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>28. Any blood disease</td><td></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>29. Kidney disease</td><td></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>30. Painful passage of urine</td><td></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>31. Blood in urine</td><td></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>32. Diabetes</td><td></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>33. Headaches /migraine</td><td></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>34. Dizziness/tainting</td><td></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>35. Epilepsy</td><td></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>36. Joints/spinal trouble</td><td></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>37. Surgical operation</td><td></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>38. Serious accident /tracture</td><td></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>39. Tropical disease</td><td></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>40. Fear of heights</td><td></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>HAVE YOU EVER BEEN:-</td><td></td><td></td></tr> <tr><td>41. Rejected for employment or insurance for medical reasons</td><td></td><td><input checked="" type="checkbox"/></td></tr> </tbody> </table>		Y	N	22. Heart Disease		<input checked="" type="checkbox"/>	23. Rheumatic Fever		<input checked="" type="checkbox"/>	24. Abnormal heartbeat		<input checked="" type="checkbox"/>	25. High blood pressure		<input checked="" type="checkbox"/>	26. Stroke		<input checked="" type="checkbox"/>	27. Serious chest pain		<input checked="" type="checkbox"/>	28. Any blood disease		<input checked="" type="checkbox"/>	29. Kidney disease		<input checked="" type="checkbox"/>	30. Painful passage of urine		<input checked="" type="checkbox"/>	31. Blood in urine		<input checked="" type="checkbox"/>	32. Diabetes		<input checked="" type="checkbox"/>	33. Headaches /migraine		<input checked="" type="checkbox"/>	34. Dizziness/tainting		<input checked="" type="checkbox"/>	35. Epilepsy		<input checked="" type="checkbox"/>	36. Joints/spinal trouble		<input checked="" type="checkbox"/>	37. Surgical operation		<input checked="" type="checkbox"/>	38. Serious accident /tracture		<input checked="" type="checkbox"/>	39. Tropical disease		<input checked="" type="checkbox"/>	40. Fear of heights		<input checked="" type="checkbox"/>	HAVE YOU EVER BEEN:-			41. Rejected for employment or insurance for medical reasons		<input checked="" type="checkbox"/>
	Y	N																																																																																																																																			
1. Sirius rouble		<input checked="" type="checkbox"/>																																																																																																																																			
2. Neck swellings/flands		<input checked="" type="checkbox"/>																																																																																																																																			
3. Difficulty in vision		<input checked="" type="checkbox"/>																																																																																																																																			
4. Any ear discharge		<input checked="" type="checkbox"/>																																																																																																																																			
5. Asthma/bronchitis		<input checked="" type="checkbox"/>																																																																																																																																			
6. Hayfever/other allergy		<input checked="" type="checkbox"/>																																																																																																																																			
7. Any skin trouble		<input checked="" type="checkbox"/>																																																																																																																																			
8. Tuberculosis		<input checked="" type="checkbox"/>																																																																																																																																			
9. Shortness of breath		<input checked="" type="checkbox"/>																																																																																																																																			
10. Coughed/vomited blood		<input checked="" type="checkbox"/>																																																																																																																																			
11. Severe abdominal pain		<input checked="" type="checkbox"/>																																																																																																																																			
12. Stomach ulcer		<input checked="" type="checkbox"/>																																																																																																																																			
13. Recurrent indigestion		<input checked="" type="checkbox"/>																																																																																																																																			
14. Jaundice or hepatitis		<input checked="" type="checkbox"/>																																																																																																																																			
15. Gall bladder disease		<input checked="" type="checkbox"/>																																																																																																																																			
16. Marked change in bowel habits		<input checked="" type="checkbox"/>																																																																																																																																			
17. Blood in stools (motions)		<input checked="" type="checkbox"/>																																																																																																																																			
18. Marked change in weight		<input checked="" type="checkbox"/>																																																																																																																																			
19. Varicose veins		<input checked="" type="checkbox"/>																																																																																																																																			
20. Lump in breast/armpit		<input checked="" type="checkbox"/>																																																																																																																																			
21. Cancer		<input checked="" type="checkbox"/>																																																																																																																																			
	Y	N																																																																																																																																			
22. Heart Disease		<input checked="" type="checkbox"/>																																																																																																																																			
23. Rheumatic Fever		<input checked="" type="checkbox"/>																																																																																																																																			
24. Abnormal heartbeat		<input checked="" type="checkbox"/>																																																																																																																																			
25. High blood pressure		<input checked="" type="checkbox"/>																																																																																																																																			
26. Stroke		<input checked="" type="checkbox"/>																																																																																																																																			
27. Serious chest pain		<input checked="" type="checkbox"/>																																																																																																																																			
28. Any blood disease		<input checked="" type="checkbox"/>																																																																																																																																			
29. Kidney disease		<input checked="" type="checkbox"/>																																																																																																																																			
30. Painful passage of urine		<input checked="" type="checkbox"/>																																																																																																																																			
31. Blood in urine		<input checked="" type="checkbox"/>																																																																																																																																			
32. Diabetes		<input checked="" type="checkbox"/>																																																																																																																																			
33. Headaches /migraine		<input checked="" type="checkbox"/>																																																																																																																																			
34. Dizziness/tainting		<input checked="" type="checkbox"/>																																																																																																																																			
35. Epilepsy		<input checked="" type="checkbox"/>																																																																																																																																			
36. Joints/spinal trouble		<input checked="" type="checkbox"/>																																																																																																																																			
37. Surgical operation		<input checked="" type="checkbox"/>																																																																																																																																			
38. Serious accident /tracture		<input checked="" type="checkbox"/>																																																																																																																																			
39. Tropical disease		<input checked="" type="checkbox"/>																																																																																																																																			
40. Fear of heights		<input checked="" type="checkbox"/>																																																																																																																																			
HAVE YOU EVER BEEN:-																																																																																																																																					
41. Rejected for employment or insurance for medical reasons		<input checked="" type="checkbox"/>																																																																																																																																			
<table border="1"> <thead> <tr> <th></th> <th>Y</th> <th>N</th> </tr> </thead> <tbody> <tr><td>42. Awarded benifities for Industrial injury/illness</td><td></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>43. Treated for a mental condition. eg . depression</td><td></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>44. Treated for problem drinking or drug abuse</td><td></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>45. Exposed to toxic substance or noise</td><td></td><td><input checked="" type="checkbox"/></td></tr> <tr><td>FOR WOMEN ONLY</td><td></td><td></td></tr> <tr><td>Have you aver had:-</td><td></td><td></td></tr> <tr><td>46. An abnormal smear</td><td></td><td></td></tr> <tr><td>47. Any gynaecological treatment</td><td></td><td></td></tr> <tr><td>48. Are you pregnant?</td><td></td><td></td></tr> <tr><td>49. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE ?</td><td></td><td></td></tr> </tbody> </table>		Y	N	42. Awarded benifities for Industrial injury/illness		<input checked="" type="checkbox"/>	43. Treated for a mental condition. eg . depression		<input checked="" type="checkbox"/>	44. Treated for problem drinking or drug abuse		<input checked="" type="checkbox"/>	45. Exposed to toxic substance or noise		<input checked="" type="checkbox"/>	FOR WOMEN ONLY			Have you aver had:-			46. An abnormal smear			47. Any gynaecological treatment			48. Are you pregnant?			49. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE ?																																																																																																						
	Y	N																																																																																																																																			
42. Awarded benifities for Industrial injury/illness		<input checked="" type="checkbox"/>																																																																																																																																			
43. Treated for a mental condition. eg . depression		<input checked="" type="checkbox"/>																																																																																																																																			
44. Treated for problem drinking or drug abuse		<input checked="" type="checkbox"/>																																																																																																																																			
45. Exposed to toxic substance or noise		<input checked="" type="checkbox"/>																																																																																																																																			
FOR WOMEN ONLY																																																																																																																																					
Have you aver had:-																																																																																																																																					
46. An abnormal smear																																																																																																																																					
47. Any gynaecological treatment																																																																																																																																					
48. Are you pregnant?																																																																																																																																					
49. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE ?																																																																																																																																					
How much tabacco each day ? NA	Average daily alcohol consupction NA																																																																																																																																				
Family history	Diabetes <input checked="" type="checkbox"/> Tuberculosis <input checked="" type="checkbox"/> Epilepsy <input checked="" type="checkbox"/> Asthama <input checked="" type="checkbox"/> Eczerna <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 <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 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 12-03-19	Signature of applicant Romjan																																																																																																																																				



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		<p>Bme : 23.09 129cm</p>							
		1. Eyes & Pupils								
		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	HEARING	VISION:	DISTANT	NEAR	COLOUR VISION	BLOOD GROUP	
165	65	126/68 mmHg	L	L	Uncorrected	R	R	(N)		
			R	R	Corrected					
N	A	LABORATORY AND SPECIAL INVESTIGATIONS				N	A			
		1. Urimalysis							6. Audiogram	
		2. Hb Bloodcount ESR							7. Lung Function	
		3. Sarum Profile							8. Chest X-Ray	
		4. Stool							9. Drug Screen	
		5. E.C.G.							10. CR Screen	

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

Bme : Healthy wt.

ASSESSMENT

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

Date 13-03-19 Signature

DR. MOHAMMAD MARUF FERDOUS
Name (Block Capitals)
MEDICAL OFFICER
RUSAYL HEALTH CENTRE
MOH LIC NO. 12930

Doctor / Sister

REVIEW/CONSULTATION

Date Signature

Name (Block Capitals) Doctor / Sister

