

#1815

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS



مکالمہ سے ملکی
RUSAYL HEALTH CENTRE
NIMR, FAHUD, QARNALAH, BHAJA, SAHRIWAL, MARMUL

INITIAL EXAMINATION REPORT

Place of examination
BahrainDate / /
05.02.19

Surname		Gurdeep Singh	
Forenames		DOB. 2-7-93, CN - 116313657	
Address		Truck Oman & Haima	
Home Telephone number		79347789	

If a dependant or fancee entr employees name jere :-

Surname :

Forenames:

		Nationality	Indian	Country of birth	India	Religion	Sikh
<input checked="" type="checkbox"/> Male	<input checked="" type="checkbox"/> Single	<input type="checkbox"/> Widower(er)	Relationship to employee				
<input type="checkbox"/> Female	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced Separated	<input checked="" type="checkbox"/> Wife	<input checked="" type="checkbox"/> Son	<input checked="" type="checkbox"/> Daughter	<input checked="" type="checkbox"/> Fiancee	
Reason for examination		Pre-employment	Job :-	mechanic			
PBO medical		Pre-overseas	Area:-	Haima			

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 (?) It unclain exclude minor ailmenis.)

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

How much tabacco each day ?

NA

Average daily alcohol consuption

NA

Family history	<input checked="" type="checkbox"/> Diabetes	<input checked="" type="checkbox"/> Tuberculosis	<input checked="" type="checkbox"/> Epilepsy	<input checked="" type="checkbox"/> Asthama	<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

05-02-19

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.		• B.M.L : 24.7 kg / m ²								
HEIGHT cm	WEIGHT kg	B.P. mmHg	HEARING L R	HEARING L R	VISION: Uncorrected Corrected	DISTANT R L	NEAR R L	COLOUR VISION	BLOOD GROUP	
166 cm	68 kg	110/80 mmHg						01		
N	A	LABORATORY AND SPECIAL INVESTIGATIONS						N	A	
1. Urimalysis 2. Hb Bloodcount ESR 3. Sarum Profile 4. Stool 5. E.C.G.										6. Audiogram 7. Lung Function 8. Chest X-Ray 9. Drug Screen 10. CR Screen
OTHER FINDINGS (physique, scars, disabilities, mental stability etc.)										
• B.M.L : Healthy wt.										

ASSESSMENT

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

Date 05.02.19 Signature

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

Doctor / Sister

REVIEW/CONSULTATION

Date

Signature

Name (Block Capitals)

Doctor / Sister

