



مركز الرسيل الصحي RUSAYL HEALTH CENTRE

ISO 9001 - 2015 Certified Co.

No. B18062

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE
ISO 9001 - 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Surname/ Forenames	ABDUL HADI SALIM MOHAMMED SULAIMAN AL-SAYED
Nationality	AL-FARSI OMANI
Mobile No.	90290005
Home/Leave Address:	
Company Number:	T: 0-10367
Reference Indicator:	

Personal Details	Civil ID: 13414004 DOB: 11/107/1993 Age: 29yrs
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A <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married <input checked="" type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced /Widow(er)
Home/Leave Address:	Relationship to employee <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter
No of Children:	

Reason for Examination (tick as appropriate)

Periodic Medical Examination ☒ Final / Retirement ☐ Other Reason: ☐

Employee only

B Present Job and Location: Next Job and Location:

Are you a registered person with special needs? ☐ Do you belong to any Medical Insurance Scheme? ☐

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
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: 13/10/2022 Signature of Applicant: HADI



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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.

HEIGHT cm	WEIGHT kg	BMI	B.P.	PULSE /mins.	HEARING L R	VISION DISTANT R L Uncorrected Corrected	NEAR R L
174	75	24.8	126 78	61	N N	6/6 6/6	6/6 with eye glass

N	A		LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A	
<input checked="" type="checkbox"/>		1. Urinalysis		<input checked="" type="checkbox"/>		7. Audiogram
<input checked="" type="checkbox"/>		2. Hb, Bloodcount, ESR				8. Lung Function
<input checked="" type="checkbox"/>		3. LFT, RFT, RBS				9. Chest X-Ray
		4. Drug Screen	N/A			10. ECG
<input checked="" type="checkbox"/>		5. Lipids (40 years +)				11. CVS risk for 40 yrs. & above
<input checked="" type="checkbox"/>		6. Sickle Cell test				12. HIV, Hepatitis screening

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

ASSESSMENT AND RECOMMENDATIONS:

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

Date: 13/10/22 Name (Block Capitals): Dr. / Nurse

Signature:

REVIEW/CONSULTATION

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

Signature:

DR. INNOCENT IFEANYI NWOKEDIUKO
GENERAL PRACTITIONER
RUSAYL HEALTH CENTRE
LIC NO. 18062

