

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE
ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Surname/Forenames		Annar, Ali Said	
Nationality		Al Forsi, Oman, Trukoruan	
Company Number:		10357	Reference Indicator:

Mobile No	97060670	Home/Leave Address:	Al Khuray
Personal Details		31y 1 DOB - 28,09,1990	
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:		<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:	Operator	Next Job and Location:	Murru
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

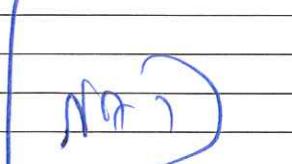
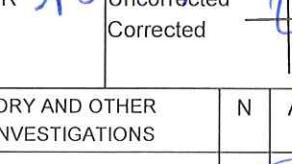
		N	Y	Description
Have you, since your last medical been treated by your family doctor or specialist for significant (major) ailments?			<input checked="" type="checkbox"/>	
1 Ear, nose, eye or throat problems			<input checked="" type="checkbox"/>	
2 Chest problems like asthma, bronchitis, other bad cough			<input checked="" type="checkbox"/>	
3 Heart abnormality, chest pains			<input checked="" type="checkbox"/>	
4 Abdominal pains, abnormal bowel motions			<input checked="" type="checkbox"/>	
5 Urogenital problems (kidney disease, menstrual disorder)			<input checked="" type="checkbox"/>	
6 Skin trouble or allergies			<input checked="" type="checkbox"/>	
7 Epileptic fits, dizzy spells or migraine			<input checked="" type="checkbox"/>	
8 History of mental illness, depression anxiety			<input checked="" type="checkbox"/>	
9 Diabetes, thyroid disease			<input checked="" type="checkbox"/>	
10 Blood disorder e.g. anaemia, blood cancer e.g. leukaemia			<input checked="" type="checkbox"/>	
11 Any history of accidents or fractures			<input checked="" type="checkbox"/>	
12 Have you had any serious allergies			<input checked="" type="checkbox"/>	
13 Do any dependants have a significant ongoing illness?			<input checked="" type="checkbox"/>	
14 Any family history of cancers			<input checked="" type="checkbox"/>	
Do you take any regular medicines, or have you taken in the past?			<input checked="" type="checkbox"/>	
Do you smoke? If yes, what and how much each day?			<input checked="" type="checkbox"/>	
Do you drink alcohol? If yes, what is your average weekly intake?			<input checked="" type="checkbox"/>	
Have you ever taken elicited/recreational drugs?			<input checked="" type="checkbox"/>	
Are you doing regular sports or physical activities?			<input checked="" type="checkbox"/>	

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: 16/05/2021	Signature of Applicant:	Stamp: RUSAYL HEALTH CENTRE
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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 <u>176</u>		WEIGHT kg <u>76</u>	BMI <u>24.5</u>	B.P. <u>114/82</u>	PULSE /mins. <u>74</u>	HEARING L <u>Normal</u>	DISTANT R <u>6/6</u>	VISION NEAR R <u>6/6</u>	VISION NEAR L <u>6/6</u>		
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					<input checked="" type="checkbox"/>		8. Lung Function		
<input checked="" type="checkbox"/>		3. LFT, RFT, RBS					<input checked="" type="checkbox"/>		9. Chest X-Ray		
<input checked="" type="checkbox"/>		4. Drug Screen					<input checked="" type="checkbox"/>		10. ECG		
<input checked="" type="checkbox"/>		5. Lipids (40 years +)					<input checked="" type="checkbox"/>		11. CVS risk for 40 yrs. & above		
<input checked="" type="checkbox"/>		6. Sickle Cell test					<input checked="" type="checkbox"/>		12. HIV, Hepatitis screening		

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

✓ NAD

ASSESSMENT AND RECOMMENDATIONS:

FIT ALL AREAS

FIT WITH RESTRICTION

TEMPORARY UNFIT

UNFIT

16/05/2021
Date: _____ Name (Block): _____

Name (Block Capitals): DR/ NURSE

DR. SANATH BUDDHIKA PRIYADARSHAN
GENERAL PRACTITIONER
(s): Dr. ~~Sanath~~ BUDDHIKA PRIYADARSHAN
RURAL HEALTH CENTRE
MOH LIC NO. 16042

Signature:

REVIEW/CONSULTATION



Date:

Name (Block Capitals): Dr. / Nurse

Signature: