



# مركز الرسيل الصحي RUSAYL HEALTH CENTRE

ISO 9001- 2015 Certified Co.

No. B 07028

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



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

PLEASE COMPLETE YOUR PERSONAL  
DETAILS IN BLOCK CAPITALS

Surname/Forenames **Ammar Ali Said**

Nationality **Al Farsi**

Mobile No **97060670**

Home/Leave Address: **Al Kuna**

Company Number: **10357**

Reference Indicator: **Truckman**

Personal Details **31y**

**DOB - 28,09,1990**

A ☒ Male ☐ Female

☐ Married

☒ Single

☐ Separated /Divorced /Widow(er)

Home/Leave Address:

Relationship to employee

☐ Wife

☐ Son

☐ 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: **Murruy**

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

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 you 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?

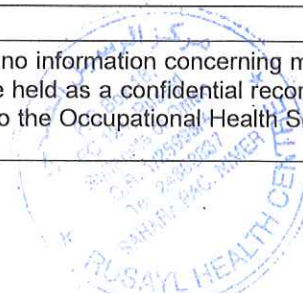
Are you doing regular sports or physical activities?

**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:

Signature of Applicant:

**16/05/2021**





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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	HEARING	VISION
176	76	24.5	114/82	74 mins.	L Normal R Normal	DISTANT R L Uncorrected Corrected 6/6 6/5

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
<input checked="" type="checkbox"/>		4. Drug Screen				10. ECG
<input checked="" type="checkbox"/>		5. Lipids (40 years +)				11. CVS risk for 40 yrs. & above
<input checked="" type="checkbox"/>		6. Sickie Cell test				12. HIV, Hepatitis screening

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

NAID

## ASSESSMENT AND RECOMMENDATIONS:

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

Date: 16/05/2021

Name (Block Capitals): Dr / Nurse

DR. SANATH BUDDHIKA PRIYADARSHAN  
GENERAL PRACTITIONER  
RUSAYL HEALTH CENTRE  
MOH LIC NO. 16042

Signature:

## REVIEW/CONSULTATION

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

Signature:

