

10351

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS



مکالمہ سیل المدرسی
RUSAYL HEALTH CENTRE
NIZR, FAHUD, QARNALAN, BHAJA, SAHRIWAL, VARVUL

INITIAL EXAMINATION REPORT

Place of examination RS PAC CLINIC BAHIA	Date 03/07/19 DJB; 01/01/1987, CIVIL-20586607, STAFF-1035
	Home Telephone number 98813434

If a dependant or fiancee entr employees name jere :-

Surname:

Forenames:

		Nationality OMAN	Country of birth OMAN	Religion ISLAM
<input checked="" type="checkbox"/> Male	<input checked="" type="checkbox"/> Single	<input checked="" type="checkbox"/> Widow(er)	Relationship to employee	
<input checked="" type="checkbox"/> Female	<input checked="" type="checkbox"/> Married	<input checked="" type="checkbox"/> Divorced Separated	<input checked="" type="checkbox"/> Wife	<input type="checkbox"/> Son <input checked="" type="checkbox"/> Daughter <input type="checkbox"/> Fiancee
			Number of Children 1	

Reason for examination Pre-employment Job :- **FOREMAN / DRIVER (LIGHT)**
 Pre-overseas Area:- **BAHJA**

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 underlain exclude minor ailmenis.)

	Y	N		Y	N		Y	N
1. Sirius rouble		✓	22. Heart Disease		✓	42. Awarded benifilis for Industrial injury/lilness		
2. Neck swellings/flands		✓	23. Rheumatic Fever		✓	43. Treated for a mental condition. eg . depression		✓
3. Difficulty in vision		✓	24. Abnormal heartbeat		✓	44. Treated for problem drinking or drug abuse		
4. Any ear discharge		✓	25. High blood pressure		✓	45. Exposed to toxic substance or noise		✓
5. Asthma/bronchitis		✓	26. Stroke		✓	FOR WOMEN ONLY		
6. Hayfever/other allergy		✓	27. Serious chest pain		✓	Have you ever had:-		
7. Any skin trouble		✓	28. Any blood disease		✓	46. An abnormal smear		
8. Tuberculosis		✓	29. Kidney disease		✓	47. Any gynaecological treatment		
9. Shortness of breath		✓	30. Painful passage of urine		✓	48. Are you pregnant?		
10. Coughed/vomited blood		✓	31. Blood in urine		✓	49. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE ?		
11. Severe abdominal pain		✓	32. Diabetes		✓			
12. Stomach ulcer		✓	33. Headaches /migraine		✓			
13. Recurrent indigestion		✓	34. Dizziness/fainting		✓			
14. Jaundice or hepatitis		✓	35. Epilepsy		✓			
15. Gall bladder disease		✓	36. Joints/spinal trouble		✓			
16. Marked change in bowel habits		✓	37. Surgical operation		✓			
17. Blood in stools (motions)		✓	38. Serious accident /fracture		✓			
18. Marked change in weight		✓	39. Tropical disease		✓			
19. Varicose veins		✓	40. Fear of heights		✓			
20. Lump in breast/armpit		✓	HAVE YOU EVER BEEN:-					
21. Cancer		✓	41. Rejected for employment or insurance for medical reasons					

How much tobacco each day? Non-smoker

Average daily alcohol consumption

Family history	Diabetes	<input checked="" type="checkbox"/>	Tuberculosis	<input checked="" type="checkbox"/>	Epilepsy	<input checked="" type="checkbox"/>	Asthma	<input checked="" type="checkbox"/>	Eczema	<input checked="" type="checkbox"/>	Blood disease	<input checked="" type="checkbox"/>
	Heart disease	<input checked="" type="checkbox"/>	High blood pressure	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	Stroke	<input checked="" type="checkbox"/>	Cancer	<input checked="" type="checkbox"/>		<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 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 03-07-19

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	<p>BMI-31.9 kg/m² HR-68b/min</p> 									
<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. Muscula-skeletal <input checked="" type="checkbox"/> 12. Skin & Varicose Vns. <input checked="" type="checkbox"/> 13. C.N.S. <input checked="" type="checkbox"/> 14. Breasts 15.		HEIGHT cm	WEIGHT kg	B.P.	HEARING L R	HEARING L R	VISION: Uncorrected Corrected	DISTANT R L	NEAR R L	COLOUR VISION	BLOOD GROUP
170	92.2	107/80									
<input checked="" type="checkbox"/> 1. Urinalysis <input checked="" type="checkbox"/> 2. Hb Bloodcount ESR <input checked="" type="checkbox"/> 3. Serum Profile <input checked="" type="checkbox"/> 4. Stool <input checked="" type="checkbox"/> 5. E.C.G.		LABORATORY AND SPECIAL INVESTIGATIONS					N	A	6. Audiogram 7. Lung Function 8. Chest X-Ray 9. Drug Screen 10. CR Screen		
		TC-233 mg/dl HDL-37.28 mg/dl LDL-139.96 mg/dl									

BMI-31.9 kg/m²
Sickle-Cell-Negative

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

Adv

- Regular exercise
- Weight reduction
- Avoid high fat diet
- Repeat RLP after 3 months

ASSESSMENT

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

Date 03-07-19

Signature

DR. HASAN SULTAN BAEZI
MEDICAL OFFICER
RUSAYL HEALTH CENTER
MOH LIC NO. 19391

Doctor / Sister

REVIEW/CONSULTATION

Date

Signature

Name (Block Capitals)

Doctor / Sister