



ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



**RUSAYL HEALTH CENTRE**

ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

25

Mobile No. <b>95251739</b>	Home/Leave Address:	Surname/Forenames <b>JO MADDER MUSA</b>
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Company Number:	Reference Indicator:
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Personal Details	<b>CIVIL ID - 11803709</b>		
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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)
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Home/Leave Address:	<input type="checkbox"/> Wife	<input type="checkbox"/> Son	<input type="checkbox"/> Daughter	No of Children:
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Reason for Examination (tick as appropriate)				
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Periodic Medical Examination <input checked="" type="checkbox"/>	Final / Retirement <input type="checkbox"/>	Other Reason: <input type="checkbox"/>		
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Employee only				
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B Present Job and Location: <b>HELPER TRUCKMAN</b>	Next Job and Location:			
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Are you a registered person with special needs? <input type="checkbox"/>	Do you belong to any Medical Insurance Scheme? <input type="checkbox"/>			
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**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				
		<b>N</b>	<b>Y</b>	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	<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?				
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: <b>1/12/2018</b>	Signature of Applicant:
<b>DR. CHIEMEKA ANDUKA EKEGHE</b> <b>GENERAL PRACTITIONER</b> <b>RUSAYL HEALTH CENTRE</b> <b>MOH LIC NO. 19798</b>	
<b>RUSAYL HEALTH CENTRE</b>	
<p style="text-align: right;">C.R. No.: 1/25995/4 P.O. Box : 18 P.C.: 124, Rusayl Sultanate of Oman</p>	

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											
✓		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. Musculo-skeletal										
✓		12. Skin & Varicose Vns.										
✓		13. C.N.S.										

HEIGHT cm	WEIGHT kg	BMI	B.P.	PULSE /mins.	HEARING L R	Uncorrected	Corrected	DISTANT R L	VISION R L	VISION NEAR R L
168	58	20.5	110/78	82	(R) N			1/6/6	6/6	1/6/6

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

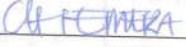
OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)

ASSESSMENT AND RECOMMENDATIONS:

FIT ALL AREAS  FIT WITH RESTRICTION  TEMPORARY UNFIT  UNFIT

FIT

Date: 9/11/2022 Name (Block Capitals): Dr. / Nurse

Signature: 

REVIEW/CONSULTATION

DR. CHEMERA NDUKA EKEGHE  
GENERAL PRACTITIONER  
RUSAYL HEALTH CENTRE  
MOH LIC NO. 19798

Signature: 

