

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS



ماليالام
RUSAYL HEALTH CENTRE
NIMR, FAHUD, GARNALAM, BHAJA, SAHRIWAL, MARWAL

INITIAL EXAMINATION REPORT

Place of examination

Date 06/07/19

RS PAC CLINIC BAHJA

Surname PONNAPPAN

Forenames AKHIL

Address TRUCKMAN

DOB: 29/12/1990, CIVIL-96923849, STAFF-96929849

Home Telephone number 79069040

If a dependant or fiancee entr employees name jere :-

Surname :

Forenames:

		Nationality INDIAN	Country of birth INDIA	Religion HINDUISM
<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 checked="" type="checkbox"/> Son
			<input checked="" type="checkbox"/> Daughter	<input checked="" type="checkbox"/> Fiancee

Reason for examination Pre-employment Job :- HELPER
 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 unclain exclude minor ailmenis.)

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

How much tabacco each day ?

Non-smoker

Average daily alcohol consupton

No

Family history	Diabetes <input checked="" type="checkbox"/>	Tuberculosis <input checked="" type="checkbox"/>	Epilepsy <input checked="" type="checkbox"/>	Asthama <input checked="" type="checkbox"/>	Eczerna <input checked="" type="checkbox"/>	Blood disease <input checked="" type="checkbox"/>
	Heart disease <input checked="" type="checkbox"/>	High blood pressure <input checked="" type="checkbox"/>		Stroke <input checked="" type="checkbox"/>	Cancer <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 06.07.19

Signature of applicant

FOR COMPLETION BY EXAMINING DOCTOR OR SISTER
FURTHER DETAILS OF MEDICAL HISTORY AND RECREATIONAL ACTIVITIES

N - Normal A - Abnormal Please Describe

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. Muscula-skeletal
✓		12. Skin & Varicose Vns.
✓		13. C.N.S.
✓		14. Breasts
		15.

PHYSICAL EXAMINATION

BME-28.1kg/m²

HR-65b/min



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
178	89.1	104/79							

N	A	LABORATORY AND SPECIAL INVESTIGATIONS	N	A
✓		1. Urimalysis		6. Audiogram
✓		2. Hb Bloodcount ESR		7. Lung Function
✓		3. Serum Profile		8. Chest X-Ray
		4. Stool		9. Drug Screen
		5. E.C.G.		10. CR Screen

BME-28.1kg/m²

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

Advt

- Regular exercise
- weight reduction
- Avoid high fat diet

ASSESSMENT

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

Date 08-07-19

Signature

DR. HASAN MAHBUB KHAN BAYZID
MEDICAL OFFICER
RUSAYL HEALTH CENTRE
MOH LIC NO. 15691

Doctor / Sister

REVIEW/CONSULTATION

Date

Signature

Name (Block Capitals)

Doctor / Sister