



TRUCK OMAN

Appendix 33: EX2 Form (Routine/Periodic Medical Examination)

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

Client ID: 18840	Reg.Dt: 24.03.2023	Surname/Forenames: BABU NANOTH	
Name: BABU NANOTH	Nationality: INDIAN		DOB: 04/07/1961
Gender: Male	Address: 70758107	Company Number:	Reference Indicator:
Mobile No. 92658357			

Personal Details

A Male Female Married Single Separated /Divorced /Widow(er)

Home/Leave Address: Relationship to employee
 Wife Son Daughter No of Children: 8

Reason for Examination (tick as appropriate)

Periodic Medical Examination Final / Retirement Other Reason:

Employee only

B Present Job and Location: MECHANIC Next Job and Location:

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, another 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 ,history of Hypertension	✓		HTN ON MEDICATION
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: 24/04/2023

Signature of Applicant: Babu



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FOR COMPLETION BY EXAMINING DOCTOR OR NURSE

Further details of medical history and recreational activities

N = Normal A = Anormal (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. 140 80 mmhg	PULSE 80 /mins.	HEARING L N R N	VISION DISTANT R L R L Uncorrected 6/6 9/9 Corrected 6/6 6/6			Color Vision ✓ 1. Normal 2. Abnormal	
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS				N	A			
✓	1. Urinalysis					✓		7. Audiogram		
✓	2. Hb, Blood count, 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:			
<input checked="" type="checkbox"/> FIT ALL AREAS	<input type="checkbox"/> FIT WITH RESTRICTION	<input type="checkbox"/> TEMPORARY UNFIT	<input type="checkbox"/> UNFIT
Date:	Name (Block Capitals): Dr. / Nurse <i>Dr. Abdul Rahman</i> Signature:		
REVIEW/CONSULTATION: <i>Mohamed</i> MOH Licence No. 1441			
Date:	Name (Block Capitals): Dr. / Nurse <i>Mukhaini</i> Signature:		

