

#1859

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS



ریسال ہیلث سینٹر
RUSAYL HEALTH CENTRE
NIRR, FAHUD, QARNALAY, BHAJA, SAHRIWAL, MARYUL

INITIAL EXAMINATION REPORT

Place of examination Date 29/08/19
RS PAC CLINIC, BAHJA

Surname IRSHAD AHMAD	
Forenames MUHAMMAD AMIN	
Address TRUCKMAN (STAFF-1859)	
DOB: 20/04/1984, CIVL-7447717	
Home Telephone number 98862197	

If a dependant or fiancee entr employees name jere :-

Surname :

Forenames:

		Nationality PAKISTAN	Country of birth PAKISTAN	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 checked="" type="checkbox"/> Son
			<input checked="" type="checkbox"/> Daughter	<input checked="" type="checkbox"/> Fiancee
			Number of Children 1	

Reason for examination Pre-employment Job: - **DRIVER**
 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 (?) If uncertain 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/lillness		<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 ever 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					

How much tabacco each day? **8-10**

Average daily alcohol consuption

N6

Family history	<input checked="" type="checkbox"/> Diabetes	<input checked="" type="checkbox"/> Tuberculosis	<input checked="" type="checkbox"/> Epilepsy	<input checked="" type="checkbox"/> Asthama	<input checked="" type="checkbox"/> Eczema
	<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"/> Blood disease

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 **29-08-19**

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>BMD-30.3 kg/m² HR-70b/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. Hermlal 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 <input checked="" type="checkbox"/> 15.											
HEIGHT cm	WEIGHT kg	B.P.	HEARING L	HEARING R	VISION: Uncorrected Corrected	DISTANT R	DISTANT A	NEAR R	NEAR A	COLOUR VISION	BLOOD GROUP
167	84.5	123/85	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
N A		LABORATORY AND SPECIAL INVESTIGATIONS						N A			
<input checked="" type="checkbox"/> 1. Urimalysis <input checked="" type="checkbox"/> 2. Hb Bloodcount ESR <input checked="" type="checkbox"/> 3. Sarum Profile <input checked="" type="checkbox"/> 4. Stool <input checked="" type="checkbox"/> 5. E.C.G.		<p>TC - 22 mg/dl HDL - 36.2 mg/dl LDL - 135.8 mg/dl</p>						<input type="checkbox"/> 6. Audiogram <input type="checkbox"/> 7. Lung Function <input type="checkbox"/> 8. Chest X-Ray <input type="checkbox"/> 9. Drug Screen <input type="checkbox"/> 10. CR Screen			

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

BMD-30.3 kg/m²

SICKLE cell- Negative

Adv-

- Regular exercise
- Weight reduction
- Avoid high fat diet

ASSESSMENT

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

Date 29-08-19


Signature

DR. HASAN MANSOOR KHAN BAYZID
MEDICAL OFFICER
RUSAYL HEALTH CENTRE
MOBILE: 968-971-5601

Doctor / Sister

REVIEW/CONSULTATION

Date

Signature

Name (Block Capitals)

Doctor / Sister