

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS



مركز الرعاية الصحية  
RUSAYL HEALTH CENTRE  
SAHARA - PAC / RS - PAC

# INITIAL EXAMINATION REPORT

Surname **SINGH**

Forenames **MUKHTAR**

Address **TRUCKOMAN (STAFF-1861)**

Place of examination

Date **19/09/19**

DOB **11/04/1962**, CIVIL **62439026**

**RS PAC CLINIC, BAHJA**

Home Telephone number **94451628**

If a dependant or fancee entr employees name jere :-

Surname :

Forenames:

Nationality **INDIAN**

Country of birth **INDIA**

Religion **SIKHISM**

☒ Male

☐ Single

☐ Widow(er)

Relationship to employee

Number of Children

☐ Female

☒ Married

☐ Divorced  
☐ Separated

☒ Wife

☐ Son

☐ Daughter

☐ Fiancee

**2**

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 ailments.)

	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/illness		<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 /tracture		<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:-		<input checked="" type="checkbox"/>			
21. Cancer		<input checked="" type="checkbox"/>	41. Rejected for employment or insurance for medical reasons		<input checked="" type="checkbox"/>			

How much tobacco each day ? **Non-smoker**

Average daily alcohol consumption **NO**

Family history

Diabetes

☒

Tuberculosis

☒

Epilepsy

☒

Asthama

☒

Eczerna

☒

Heart disease

☒

High blood pressure

☒

Stroke

☒

Cancer

☒

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 **19-09-19**

Signature of applicant

*[Signature]*

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

N - Normal A - Abnormal Please Describe		PHYSICAL EXAMINATION
✓	1. Eyes & Pupils	<p>BMC-28.4 kg/m<sup>2</sup> HR-73b/min</p> 
✓	2. E.N.T.	
✓	3. Teeth & Mouth	
✓	4. Lungs & Chest	
✓	5. Cardiovascular System	
✓	6. Abdo. Viscera	
✓	7. Hemial Orifices	
✓	8. Anus & Rectum	
✓	9. Genito - urinary	
✓	10. Extremities	
✓	11. Muscula-skeletal	
✓	12. Skin & Varicose Vns.	
✓	13. C.N.S.	
✓	14. Breasts	
	15.	

HEIGHT cm	WEIGHT kg	B.P.	HEARING L	HEARING R	VISION: Uncorrected	VISION: Corrected	DISTANT R L	NEAR R L	COLOUR VISION	BLOOD GROUP
168.6	80.8	136/89								

N	A	LABORATORY AND SPECIAL INVESTIGATIONS	N	A
✓	1. Urinalysis	HDL-26mg/dl		6. Audiogram
✓	2. Hb Bloodcount ESR			7. Lung Function
✓	3. Sarum Profile			8. Chest X-Ray
✓	4. Stool			9. Drug Screen
✓	5. E.C.G.			10. CR Screen

BMC-28.4 kg/m<sup>2</sup>  
Stroke cell- Negative  
OTHER FINDINGS (physique, scars, disabilities, mental stability etc.)

A Thin gentleman underwent TMT on 30.09.19 and was found to have negative TMT for stress induced ischaemia. Therefore, he has been mentioned FTW as a driver.

ASSESSMENT

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

Date 14.10.19

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