

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)

RUSAYL HEALTH CENTRE
PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Surname/ Forenames:		Harjit Singh 40yrs/m
Nationality:		INDIAN

Mobile No. 72693971	Home/Leave Address: INDIA	Company Number: 1870	Reference Indicator: TRUCK OMAN
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Personal Details

A <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced
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Home/Leave Address: INDIA	Relationship To Employee <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)

Periodic Medical Examination <input type="checkbox"/> Initial <input checked="" type="checkbox"/> Periodic
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Employee Only

B Present Job And Location: MARMUL - Crane Operator	Next Job And Location: MARMUL
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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

	N	Y	Description
Have You, Since Your Last Medical Been Treated By Your Family Doctor Or Specialist For Significant (major) Ailments?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Ear, Nose, Eye Or Throat Problems	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Chest Problems Like Asthma, Bronchitis, Other Bad Cough	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Heart Abnormality, Chest Pains	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Abdominal Pains, Abnormal Bowel Motions	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Urogenital Problems (kidney Disease, Menstrual Disorder)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Skin Trouble Or Allergies	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Epileptic Fits, Dizzy Spells Or Migraine	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
History Of Mental Illness, Depression Anxiety	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Diabetes, Thyroid Disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Blood Disorder E.G. Anaemia, Blood Cancer E.G. Leukaemia	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Any History Of Accidents Or Fractures	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Have You Had Any Serious Allergies	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Any Family History Of Cancers	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Do You Take Any Regular Medicines, Or Have You Taken In The Past	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Do You Smoke? If Yes, What And How Much Each Day?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Do You Drink Alcohol? If Yes, What Is Your Average Weekly Intake?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Have You Ever Taken Elicted/recreational Drugs?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Are You Doing Regular Sports Or Physical Activities?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	

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: 25/09/2023	Signature: Harjit Singh
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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		
<input type="checkbox"/>	<input type="checkbox"/>	Eyes Pupils	
<input type="checkbox"/>	<input type="checkbox"/>	ENT	
<input type="checkbox"/>	<input type="checkbox"/>	Teeth Mouth	
<input type="checkbox"/>	<input type="checkbox"/>	Lungs Chest	
<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular System	
<input type="checkbox"/>	<input type="checkbox"/>	Abdo Viscera	
<input type="checkbox"/>	<input type="checkbox"/>	Hernal Orifices	
<input type="checkbox"/>	<input type="checkbox"/>	Anus Rectum	
<input type="checkbox"/>	<input type="checkbox"/>	Genito Urinary	
<input type="checkbox"/>	<input type="checkbox"/>	Extremities	
<input type="checkbox"/>	<input type="checkbox"/>	Musculo Skeletal	
<input type="checkbox"/>	<input type="checkbox"/>	Skin Varicose Vns	
<input type="checkbox"/>	<input type="checkbox"/>	Cns	

HEIGHT 175 Cm	WEIGHT 91 Kg	BMI 30	B.P 124/84	PULSE 82/mins	HEARING L: NORMAL R: NORMAL	VISION: RIGHT 6/6 , LEFT 6/6	Colour Vision: N	Blood Group: N/A
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N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS		N	A		
<input type="checkbox"/>	<input type="checkbox"/>	1.Urinalysis		<input type="checkbox"/>	<input type="checkbox"/>	7.Audiogram	
<input type="checkbox"/>	<input type="checkbox"/>	2 Hb, Bloodcount, ESR		<input type="checkbox"/>	<input type="checkbox"/>	8. Lung Function	
<input type="checkbox"/>	<input type="checkbox"/>	3 LFT, RFT, RBS/FBS		<input type="checkbox"/>	<input type="checkbox"/>	9. Chest X-Ray	
<input type="checkbox"/>	<input type="checkbox"/>	4. Drug Screen		<input type="checkbox"/>	<input type="checkbox"/>	10. ECG	
<input type="checkbox"/>	<input type="checkbox"/>	5. Lipids (40 Years +)		<input type="checkbox"/>	<input type="checkbox"/>	11. CVD Risk For 40 Yrs. & Above	
<input type="checkbox"/>	<input type="checkbox"/>	6. Sickle Cell Test		<input type="checkbox"/>	<input type="checkbox"/>	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

A 10 - aerobic respiration, for fast 20 mins, 10 min exercise

Date: 25/09/2023 Name (Block Capitals). Dr. Dr-Buddhi

Signature: *DR. SANATH BUDDHIKA PRIYADARSHAN*

DR. SANATH BUDDHIKA PRIYADARSHAN
GENERAL PRACTITIONER
RUSAYL HEALTH CENTRE
P.O. Box: 18, P.C.: 124, Rusayl
Sultanate of Oman

REVIEW/CONSULTATION: *Low risk for OSA*

Date: 25/09/2023 Name (Block Capitals). Dr.

Signature: *SAHARA NIMR*

رسيل الصحي
RUSAYL HEALTH CENTRE
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P.O. Box: 18, P.C.: 124, Rusayl
Sultanate of Oman