



مرکز الرسیل الصحي RUSAYL HEALTH CENTRE

ISO 9001 - 2015 Certified Co.

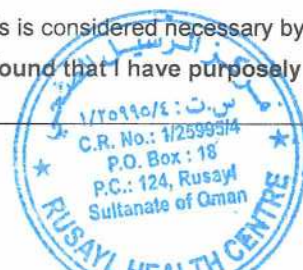
INITIAL EXAMINATION REPORT (MEDICAL - CONFIDENTIAL) No. A 0229



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PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Place of examination		Date 24-10-19		Surname LALMIYA KHAN	
If a dependant enter employee's name here: Surname:		Forenames: LALMIYA		Address TRUCKMAN	
Birth date 10/07/1996		Nationality: BANGLADESHI		Home telephone number 9405213	
Country of birth: BANGLADESH		Religion: ISLAM		Forenames:	
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		<input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced		Relationship to employee <input checked="" type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	
Reason for examination		Pre-Employment <input checked="" type="checkbox"/> Pre-Overseas <input type="checkbox"/>		Job: HELPER	
Name and address of family doctor		Area: BAHJA		Number of children: 1	
List your last 3 jobs		(1)		(2)	
Are you a Registered Disabled Person? (UK only) <input type="checkbox"/>		Do you belong to any Medical Insurance Scheme? <input type="checkbox"/>		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. Sinus trouble		<input checked="" type="checkbox"/>		21. Cancer	
2. Neck swelling/glands		<input checked="" type="checkbox"/>		22. Heart Disease	
3. Difficulty in vision		<input checked="" type="checkbox"/>		23. Rheumatic fever	
4. Any ear discharge		<input checked="" type="checkbox"/>		24. Abnormal heartbeat	
5. Asthma/bronchitis		<input checked="" type="checkbox"/>		25. High blood pressure	
6. Hayfever /other significant allergy		<input checked="" type="checkbox"/>		26. Stroke	
7. Any skin trouble		<input checked="" type="checkbox"/>		27. Serious chest pain	
8. Tuberculosis		<input checked="" type="checkbox"/>		28. Any blood disease	
9. Shortness of breath		<input checked="" type="checkbox"/>		29. Kidney disease	
10. Coughed/vomited blood		<input checked="" type="checkbox"/>		30. Blood in urine	
11. Severe abdominal pain		<input checked="" type="checkbox"/>		31. Diabetes	
12. Stomach ulcer		<input checked="" type="checkbox"/>		32. Headaches/migraine	
13. Recurrent indigestion		<input checked="" type="checkbox"/>		33. Dizziness/fainting	
14. Jaundice or hepatitis		<input checked="" type="checkbox"/>		34. Epilepsy	
15. Gall Bladder disease		<input checked="" type="checkbox"/>		35. Joints/spinal trouble	
16. Marked change in bowel habits		<input checked="" type="checkbox"/>		36. Surgical operation	
17. Blood in stools (motions)		<input checked="" type="checkbox"/>		37. Serious accident/fracture	
18. Marked change in weight		<input checked="" type="checkbox"/>		38. Tropical disease	
19. Varicose veins		<input checked="" type="checkbox"/>		39. Fear of heights	
20. Lump in breast/arm/pit		<input checked="" type="checkbox"/>			
How much tobacco each day? 8-10		Average daily alcohol consumption NA		HAVE YOU EVER BEEN:-	
Have you ever taken elicited drugs? (x)		PDO test all new/potential employees for elicited/recreational drugs		40. Rejected for employment or insurance for medical reasons	
FAMILY HISTORY: Diabetes (x) Tuberculosis (x) Epilepsy (x) Asthma (x) Eczema (x)		Heart disease (x) High blood pressure (x) Stroke (x) Blood Disease (x) Cancer (x)		41. Awarded benefits for industrial injury/illness	
PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT:-		I declared these statements to be true to the best of my knowledge and belief and I agree that the result of this medical examination 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. I am also aware that PDO reserve the right to dismiss me if it was found that I have purposely withheld important medical information.		42. Treated for a mental condition, e.g. depression	
				43. Treated for problem drinking or drug abuse	
				44. Exposed to toxic substance or noise	
				FOR WOMEN ONLY	
				Have you ever had:-	
				45. An abnormal smear	
				46. Any gynaecological treatment	
				47. Are you pregnant?	
				48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE	
Date: 24-10-19		Signature of Applicant: LALMIYA			



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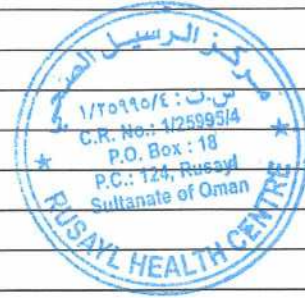
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FOR COMPLETION BY EXAMINING DOCTOR OR NURSE
Further details of medical history and recreational activities

N = Normal A = Abnormal (please describe)

PHYSICAL EXAMINATION

N	A	
✓		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.	PULSE	HEARING	VISION	Colour Vision	Blood Group
163	46.7	17.6	100 74	79/min.	L > R	DISTANT R L Uncorrected Corrected	2	-

N	A		LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A	
✓		1. Urinalysis	HDL-28mg/dl			7. Audiogram
✓		2. Hb, Bloodcount, 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. Sickie Cell test				12. HIV, Hepatitis screening

OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)

ASSESSMENT:

☒ FIT ALL AREAS ☐ FIT WITH RESTRICTION ☐ TEMPORARY UNFIT ☐ UNFIT

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

Date: 24.10.19 Name (Block Capitals): Dr. / Nurse

Signature:

REVIEW/CONSULTATION

Date: Name (Block Capitals): Dr. / Nurse

Signature: