

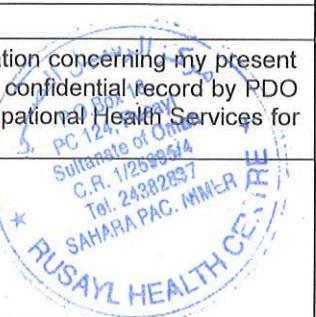
ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE

ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Mobile No	94032193	Home/Leave Address:	Pakistan	Company Number:	1874	Reference Indicator:
Personal Details		49Y 1D06 - 03,09,1972 / 11.79396975				
A <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		<input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced /Widow(er)				
Home/Leave Address:		Relationship to employee			No of Children: 04	
Reason for Examination (tick as appropriate)						
Periodic Medical Examination <input checked="" type="checkbox"/>		Final / Retirement <input type="checkbox"/>		Other Reason: <input type="checkbox"/>		
Employee only						
B Present Job and Location: HDS		Next Job and Location: NMV				
Are you a registered person with special needs? <input type="checkbox"/>		Do you belong to any Medical Insurance Scheme? <input type="checkbox"/>				
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, other 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					
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?		<input checked="" type="checkbox"/> DM on Medications				
Do you smoke? If yes, what and how much each day?		<input checked="" type="checkbox"/> AS a 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?		<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.						
03/10/2021		M ASIB				
Date:		Signature of Applicant:				
						

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. mm Hg	PULSE bpm	HEARING L R	Normal Normal Uncorrected Corrected	DISTANT R L	VISION R L
165	69	25	118 84	66	L R	Normal Normal Uncorrected Corrected	✓ ✓	✓ ✓

N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A
✓	1. Urinalysis <i>repeat - Normal</i>		✓	7. Audiogram
✓	2. Hb, Bloodcount, ESR			8. Lung Function
✓	3. LFT, RFT, RBS <i>259 → 142</i>			9. Chest X-Ray
	4. Drug Screen			10. ECG
✓	5. Lipids (40 years +) <i>HDL - 39.21</i>			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.)

*A advise to continue medications for oral if
regular exercise, diet control).*

ASSESSMENT AND RECOMMENDATIONS:

FIT ALL AREAS FIT WITH RESTRICTION TEMPORARY UNFIT UNFIT

Within follow up & medications.

Date: 10/10/2021

Name (Block Capitals): Dr. / Nurse

REVIEW/CONSULTATION

GENERAL PRACTITIONER
RUSAYL HEALTH CENTRE
MOH LIC NO. 16042

Date:

Name (Block Capitals): Dr. / Nurse

Signature:



Signature: