

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE

ISO 9001-2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Surname/
Forenames SREENATH GOPINATHAN PILLAI

Nationality INDIAN, CIVIL 76762054, DOB: 26/05/1976

Mobile No. 97458535	Home/Leave Address:	Company Number: 6211	Reference Indicator: TRUCK01MA1
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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 /Widow(er)
Home/Leave Address:	Relationship to employee <input checked="" type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter
No of Children: 1	

Reason for Examination (tick as appropriate)

Periodic Medical Examination <input checked="" type="checkbox"/>	Final / Retirement <input checked="" type="checkbox"/>	Other Reason: <input type="checkbox"/>
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Employee only

B Present Job and Location: WORKSHOP FOREMAN, BAHJA	Next Job and Location: NA
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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?	✓		
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?	✓		
Do you smoke? If yes, what and how much each 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?	✓		

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: 11.01.20

Signature of Applicant:

[Signature]
11. Jan. 2020

FOR COMPLETION BY EXAMINING DOCTOR OR NURSE

Further details of medical history and recreational activities

		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. 110 78	PULSE 79 /mins.	HEARING L R R	VISION	
						DISTANT R L	NEAR R L
160	67.0	26.2				Uncorrected Q1 Q1	Q1 Q1
						Corrected X X	X X

N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A
✓		1. Urinalysis		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. Sickle Cell test		12. HIV, Hepatitis screening

OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)													
ADY Resection scar Weight reduction													

ASSESSMENT AND RECOMMENDATIONS:													
<input checked="" type="checkbox"/> FIT ALL AREAS <input type="checkbox"/> FIT WITH RESTRICTION <input type="checkbox"/> TEMPORARY UNFIT <input type="checkbox"/> UNFIT										Ammar			

Date: 11.01.20	Name (Block Capitals): Dr. / Nurse	Signature:
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REVIEW/CONSULTATION													

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