

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE

ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Surname/ Forenames <i>Prasheed Mundu</i> <i>Achali</i>																																																																	
Nationality <input checked="" type="checkbox"/> Indian																																																																	
Company Number: 1896 Reference Indicator: Truikuan																																																																	
Personal Details <i>S29 1/03 - 18,05,1970 / ID-12060956</i>																																																																	
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: <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter No of Children:																																																																	
Reason for Examination (tick as appropriate) <input checked="" type="checkbox"/> Periodic Medical Examination <input type="checkbox"/> Final / Retirement <input type="checkbox"/> Other Reason:																																																																	
Employee only B Present Job and Location: <i>HDIS</i> Next Job and Location: <i>NIMY</i>																																																																	
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																																																																	
<table border="1"> <thead> <tr> <th></th> <th>N</th> <th>Y</th> <th>Description</th> </tr> </thead> <tbody> <tr> <td>Have you, since your last medical been treated by your family doctor or specialist for significant (major) ailments?</td> <td></td> <td></td> <td></td> </tr> <tr> <td>1 Ear, nose, eye or throat problems</td> <td></td> <td></td> <td></td> </tr> <tr> <td>2 Chest problems like asthma, bronchitis, other bad cough</td> <td></td> <td></td> <td></td> </tr> <tr> <td>3 Heart abnormality, chest pains</td> <td></td> <td></td> <td></td> </tr> <tr> <td>4 Abdominal pains, abnormal bowel motions</td> <td></td> <td></td> <td></td> </tr> <tr> <td>5 Urogenital problems (kidney disease, menstrual disorder)</td> <td></td> <td></td> <td></td> </tr> <tr> <td>6 Skin trouble or allergies</td> <td></td> <td></td> <td></td> </tr> <tr> <td>7 Epileptic fits, dizzy spells or migraine</td> <td></td> <td></td> <td></td> </tr> <tr> <td>8 History of mental illness, depression anxiety</td> <td></td> <td></td> <td></td> </tr> <tr> <td>9 Diabetes, thyroid disease</td> <td></td> <td></td> <td></td> </tr> <tr> <td>10 Blood disorder e.g. anaemia, blood cancer e.g. leukaemia</td> <td></td> <td></td> <td></td> </tr> <tr> <td>11 Any history of accidents or fractures</td> <td></td> <td></td> <td></td> </tr> <tr> <td>12 Have you had any serious allergies</td> <td></td> <td></td> <td></td> </tr> <tr> <td>13 Do any dependants have a significant ongoing illness?</td> <td></td> <td></td> <td></td> </tr> <tr> <td>14 Any family history of cancers</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>			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			
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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.																																																																	
<i>31/01/2022</i>																																																																	
Date: <i>31/01/2022</i> Signature of Applicant: <i>Prasheed</i>																																																																	

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 mins.	HEARING L	HEARING R	VISION DISTANT R	VISION NEAR R
170	100	34.6	124/86	73	Normal	Normal	6/6	6/6

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.)

A 2vise 2 on oragna fl 2ultron,
Loor fat 2eta, Regnar Exercis.

ASSESSMENT AND RECOMMENDATIONS:

FIT ALL AREAS FIT WITH RESTRICTION TEMPORARY UNFIT UNFIT

31/01/2022

Name (Block Capitals): Dr. / Nurse


Signature:

REVIEW/CONSULTATION

Date:

Name (Block Capitals): Dr. / Nurse

Signature:

