



# مركز الرسيل الصحي RUSAYL HEALTH CENTRE

ISO 9001 - 2015 Certified Co.

No. B 3836

## ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



### RUSAYL HEALTH CENTRE

ISO 9001 - 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL  
DETAILS IN BLOCK CAPITALS

Surname/  
Forenames

ARIF HUSSAIN

Nationality

PAKISTANI (ID NO: 95375552)

Mobile No. 91358288

Home/Leave Address:

TRUCK OMEN

Company Number:

Reference Indicator:

Personal Details

DOB: 15/12/84

AGE: 36 YRS

A ☒ Male ☐ Female

☒ Married ☐ Single ☐ Separated /Divorced /Widow(er)

Home/Leave Address:

Relationship to employee

☐ Wife ☐ Son ☐ Daughter

No of Children: 4

Reason for Examination (tick as appropriate)

Periodic Medical Examination ☒

Final / Retirement ☐

Other Reason: ☐

Employee only

B Present Job and Location:

TRUCK OMEN FONE LIFT OPERATOR

Next Job and Location:

Are you a registered person with special needs? ☐

Do you belong to any Medical Insurance Scheme?

**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 your 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?	/		

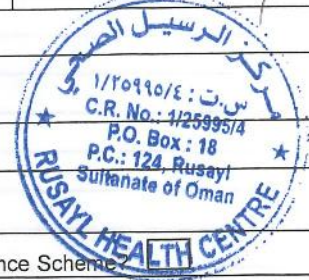
**STATEMENT:** I have read the above questions and the above answers are correct and no information concerning my present or past state of health has been withheld. I understand and agree that this form will be held as a confidential record by PDO Medical Department, and may be copied (by paper or secure electronic transmission) ) to the Occupational Health Services for the purpose of Health Surveillance and other Occupational Health review.

Date:

24/09/20

Signature of Applicant:

كارن حسين





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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 L R	VISION DISTANT NEAR
169	90	31.5	124 98	80 /mins.	(N)	Uncorrected Corrected
						R L R L
						6/6 6/6 N N

Color vision (N)

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. Sickie Cell test				12. HIV, Hepatitis screening

FBS = 100mg/dl  
9 Insigantles  
4 HDL

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

Dietary & lifestyle changes & Low risk for review in 3/12

## ASSESSMENT AND RECOMMENDATIONS:

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

Date: 24/09/20 Name (Block Capitals): Dr. / Nurse

Signature:


REVIEW/CONSULTATION

DR. JUDE NNAMDI UGWUJA  
GENERAL PRACTITIONER  
RUSAYL HEALTH CENTRE  
MOH LIC NO 18259

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

Signature:

## Fitness to Work Certificate for Drivers

<b>Employee Data</b>		<b>Date: 24-SEPTEMBER-2020</b>	
Name: ARIF HUSSAIN		Department/Company: TRUCK OMAN	
I.D No. 95375552	Age: 36	Occupation: FORKLIFT OPERATOR	
<b>Type of Medical Evaluation</b>		<b>Mark those applying ✓</b>	
A5 HVD- Crane or forklift driving & all heavy vehicles		A7 Professional driving- Light Vehicles	
<p>Health Advisor Statement : The above named person has been examined according to the statements laid down in "Protocols and Guidance Notes on the Medical Evaluation of Fitness to Work". At this time his/her fitness to work status for the above tasks is as follows.</p>			
Fit with no restrictions		✓	
Fit with following restriction(s)			
<i>The employee is fit for above work but should avoid the following task(s)</i>	<i>Temporary restriction</i>	<i>Permanent restriction</i>	
Work near moving machinery or sharp edges			
Operate heavy/light motor vehicles, forklifts or heavy machinery			
Other (Specify)			
Temporary Unfit until			
Permanently Unfit		Date	
Name of Health Advisor Signature  Date			

**DR. JUDE NNAMDI UGWUJA**  
 GENERAL PRACTITIONER  
 RUSAYL HEALTH CENTRE  
 MOH LIC NO 18259

