

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

 <b>RUSAYL HEALTH CENTRE</b> <small>ISO 9001- 2015 Certified Co.</small>		<b>Surname/Forenames</b> <small>MUHAMMAD FARYAD muhammad IBRAHIM</small>		
<b>PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS</b>		<b>Nationality</b> <small>PAKISTANI (ID NO: 91425613)</small>		
<b>Mobile No.</b> 96840218	<b>Home/Leave Address:</b> <small>TAJUQ, OMAN</small>	<b>Company Number:</b>	<b>Reference Indicator:</b>	
<b>Personal Details</b> <small>DOB: 25/03/87</small>		<small>AGE: 33 yrs</small>		
<small>A <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female</small>		<small><input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced /Widow(er)</small>		
<b>Home/Leave Address:</b>		<small>Relationship to employee</small> <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	<small>No of Children: 4</small>	
<b>Reason for Examination (tick as appropriate)</b>				
<small>Periodic Medical Examination <input checked="" type="checkbox"/></small>		<small>Final / Retirement <input type="checkbox"/></small>		
<small>Other Reason: <input type="checkbox"/></small>		<small>س.ر.ل.الرسيل الصحي</small> <small>ر.س. ١٢٥٩٩٥٤</small> <small>C.R. No.: 1259954</small> <small>★ P.O. Box: 18</small> <small>P.C.: 124, Rusayl</small> <small>Sultanate of Oman</small>		
<b>B. Present Job and Location:</b> OMAN ALIYAN CAVAN OPERATOR <b>Next Job and Location:</b>				
<small>Are you a registered person with special needs? <input type="checkbox"/></small>		<small>Do you belong to any Medical Insurance Scheme? <input type="checkbox"/></small>		
<b>Previous Medical History:</b> All important medical events should be listed and dated at every medical examination. This will be completed together with the interviewing Nurses or Doctor who will be able to help by referring to your notes.				
<b>Please answer the following questions and tick 'N' (no) or 'Y' (yes) in the column. If 'Y' Please describe</b>				
		<b>N</b>	<b>Y</b>	<b>Description</b>
<small>Have you, since your last medical been treated by your family doctor or specialist for significant (major) ailments?</small>		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
<small>1 Ear, nose, eye or throat problems</small>		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
<small>2 Chest problems like asthma, bronchitis, other bad cough</small>		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
<small>3 Heart abnormality, chest pains</small>		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
<small>4 Abdominal pains, abnormal bowel motions</small>		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
<small>5 Urogenital problems (kidney disease, menstrual disorder)</small>		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
<small>6 Skin trouble or allergies</small>		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
<small>7 Epileptic fits, dizzy spells or migraine</small>		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
<small>8 History of mental illness, depression anxiety</small>		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
<small>9 Diabetes, thyroid disease</small>		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
<small>10 Blood disorder e.g. anaemia, blood cancer e.g. leukaemia</small>		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
<small>11 Any history of accidents or fractures</small>		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
<small>12 Have you had any serious allergies</small>		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
<small>13 Do any dependants have a significant ongoing illness?</small>		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
<small>14 Any family history of cancers</small>		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
<small>Do you take any regular medicines, or have you taken in the past?</small>		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
<small>Do you smoke? If yes, what and how much each day?</small>		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
<small>Do you drink alcohol? If yes, what is your average weekly intake?</small>		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
<small>Have you ever taken elicited/recreational drugs?</small>		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
<small>Are you doing regular sports or physical activities?</small>		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
<small><b>STATEMENT:</b> 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.</small>				
<small>Date: 22/09/20</small>		<small>Signature of Applicant:</small>		

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. 120 80	PULSE 68 /mins.	HEARING L R (N)	VISION	
						DISTANT R L	NEAR R L
164	78.2	29.1				Uncorrected 6/6 6/6	Corrected N/N

LABORATORY AND OTHER  
SPECIAL INVESTIGATIONS

N	A		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.)

Dietary & lifestyle modifications; I work (my review in 3/12)

ASSESSMENT AND RECOMMENDATIONS:

FIT ALL AREAS  FIT WITH RESTRICTION  TEMPORARY UNFIT  UNFIT

Date: 22/03/20 Name (Block Capitals): Dr. / Nurse

DR. JUDE NYAMIDI UGWUJA  
PRACTITIONER  
RUSAYL HEALTH CENTRE  
MOH LIC NO. 18269

Signature: 

REVIEW/CONSULTATION

Date:

Name (Block Capitals): Dr. / Nurse

Signature:

.., Rusayl  
Code : 124  
Sultanate of Oman  
Tel.: 24446151 / 54  
Fax : 24446833



Timing : O.P.D. 7 a.m. to 5 p.m.

Date : 22/09/2020

## LABORATORY INVESTIGATION

Name : <u>Mohammed Farayad</u>		Sex : <u>M</u> Age : <u>33</u>																																																										
Dr. : <u>Touk Oman</u>																																																												
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Medical Officer

GENERAL PRACTITIONER  
RUSAYL HEALTH CENTRE  
NOM. LIC NO. 18259

Lab. Technician

## Fitness to Work Certificate for Drivers

<b>Employee Data</b>		<b>Date: 22-SEPTEMBER-2020</b>		
Name: MUHAMMAD FARYAD MUHAMMAD IBRAHIM		Department/Company: TRUCK OMAN		
I.D No. 91425613	Age: 33	Occupation: CRANE OPERATOR		
<b>Type of Medical Evaluation</b> <span style="float: right;">Mark those applying <input checked="" type="checkbox"/></span>				
A5 HVD- Crane or forklift driving & all heavy vehicles		<input type="checkbox"/>	A7 Professional driving- Light Vehicles	<input type="checkbox"/>
<b>Health Advisor Statement :</b> 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.				
Fit with no restrictions			<input checked="" type="checkbox"/>	
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		<input type="checkbox"/>	<input type="checkbox"/>	
Operate heavy/light motor vehicles, forklifts or heavy machinery		<input type="checkbox"/>	<input type="checkbox"/>	
Other (Specify)		<input type="checkbox"/>	<input type="checkbox"/>	
Temporary Unfit until				
Permanently Unfit			<b>Date</b>	
Name of Health Advisor		Signature 	Date <b>22-SEPTEMBER-2020</b>	

DR. JUNDE NWANDI UGWUWA  
 GENERAL PRACTITIONER  
 RUSAYL HEALTH CENTRE  
 MOH LIC NO. 18289