

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>MOHAMMED NASSER</i>	
Nationality		<i>OMAN</i>	

Mobile No. <i>9409732</i>	Home/Leave Address:	Company Number:	Reference Indicator:
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Personal Details		<i>31 years</i>	
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A <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married <input checked="" type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced /Widow(er)
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Home/Leave Address:	Relationship to employee	No of Children:
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Reason for Examination (tick as appropriate)			
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Periodic Medical Examination <input type="checkbox"/>	Final / Retirement <input type="checkbox"/>	Other Reason: <input type="checkbox"/>
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Employee only			
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B) Present Job and Location: <i>HD TRUCKMAN</i>	Next Job and Location:
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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	<input checked="" type="checkbox"/>	
2 Chest problems like asthma, bronchitis, other bad cough	<input checked="" type="checkbox"/>	
3 Heart abnormality, chest pains	<input checked="" type="checkbox"/>	
4 Abdominal pains, abnormal bowel motions	<input checked="" type="checkbox"/>	
5 Urogenital problems (kidney disease, menstrual disorder)	<input checked="" type="checkbox"/>	
6 Skin trouble or allergies	<input checked="" type="checkbox"/>	
7 Epileptic fits, dizzy spells or migraine	<input checked="" type="checkbox"/>	
8 History of mental illness, depression anxiety	<input checked="" type="checkbox"/>	
9 Diabetes, thyroid disease	<input checked="" type="checkbox"/>	
10 Blood disorder e.g. anaemia, blood cancer e.g. leukaemia	<input checked="" type="checkbox"/>	
11 Any history of accidents or fractures	<input checked="" type="checkbox"/>	
12 Have you had any serious allergies	<input checked="" type="checkbox"/>	
13 Do any dependants have a significant ongoing illness?	<input checked="" type="checkbox"/>	
14 Any family history of cancers	<input checked="" type="checkbox"/>	
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: <i>30/08/22</i>	Signature of Applicant: <i>[Signature]</i>
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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. 100 70	PULSE /mins.	HEARING L R	Uncorrected Corrected	VISION			
							DISTANT R L	NEAR R L		
159	71	28.6	70	70						

N	A		LABORATORY AND OTHER SPECIAL INVESTIGATIONS		N	A	
		1. Urinalysis	Hb - 13.6 g/dl ↓				7. Audiogram
		2. Hb, Bloodcount, ESR	Hct 37.5 ↓				8. Lung Function
		3. LFT, RFT, RBS	MCV 87.5 ↓				9. Chest X-Ray
		4. Drug Screen	MCH - 26.8 ↓				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.)

Mild - moderate hearing loss
Hb - 13.6 g/dl
Hct - 37.5

ASSESSMENT AND RECOMMENDATIONS:

FIT ALL AREAS FIT WITH RESTRICTION TEMPORARY UNFIT UNFIT
FIT WITH RESTRICTION ~~AT UNFIT review advised (mild-mod) hearing loss~~

Date: 30/10/22 Name (Block Capitals): Dr. / Nurse

CHTEMKA

Signature: 

REVIEW/CONSULTATION

Please operate light vehicles till Audiometry review
by ENT surgeon.
Non Rich foods (Balanced diet) vegetable advised

Date: 30/10/22

Name (Block Capitals): Dr. / Nurse

CHTEMKA

Signature: 