

6364

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS



الرعي الصحي
RUSAYL HEALTH CENTRE
HHR, FAHUD, QARNAVAY, BHAJA, SAHRIVAL, KARJUL

INITIAL EXAMINATION REPORT

Place of examination RS PAC CLINIC BAHJA	Date 13.07.19	DOB: 30/01/1973, CIVIL-85409033, STAFF-6364
		Home Telephone number 93503347

If a dependant or fiancee entr employees name jere :-

Surname :

Forenames:

	Nationality INDIAN	Country of birth INDIA	Religion SIKHISM
<input checked="" type="checkbox"/> Male	<input checked="" type="checkbox"/> Single	<input checked="" type="checkbox"/> Widow(er)	Relationship to employee
<input type="checkbox"/> Female	<input checked="" type="checkbox"/> Married	<input checked="" type="checkbox"/> Divorced Separated	<input checked="" type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input checked="" type="checkbox"/> Fiancee
Number of Children	2		

Reason for examination	<input checked="" type="checkbox"/> Pre-employment	Job :- DRIVER (HEAVY)
	<input type="checkbox"/> Pre-overseas	Area:- BAHJA
Name and address of family doctor	List your last 3 jobs	
	(1)	
	(2)	
	(3)	

Are you Registered Disabled Person? (UK) Do you belong to any Medical Insurance Scheme?

DO YOU HAVE OR HAVE YOU HAD :- (Tick 'yes' or 'No' column or put a (?) It uncertain exclude minor ailmenis.)

	Y	N		Y	N		Y	N
1. Sirius rouble		✓	22. Heart Disease		✓	42. Awarded benifities for Industrial injury/lillness		
2. Neck swellings/llands		✓	23. Rheumatic Fever		✓	43. Treated for a mental condition. eg . depression		
3. Difficulty in vision		✓	24. Abnormal heartbeat		✓	44. Treated for problem drinking or drug abuse		
4. Any ear discharge		✓	25. High blood pressure		✓	45. Exposed to toxic substance or noise		
5. Asthma/bronchitis		✓	26. Stroke		✓	FOR WOMEN ONLY		
6. Hayfever/other allergy		✓	27. Serious chest pain		✓	Have you ever had:-		
7. Any skin trouble		✓	28. Any blood disease		✓	46. An abnormal smear		
8. Tuberculosis		✓	29. Kidney disease		✓	47. Any gynaecological treatment		
9. Shortness of breath		✓	30. Painful passage of urine		✓	48. Are you pregnant?		
10. Coughed/vomited blood		✓	31. Blood in urine		✓	49. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE ?		
11. Severe abdominal pain		✓	32. Diabetes		✓			
12. Stomach ulcer		✓	33. Headaches /migraine		✓			
13. Recurrent indigestion		✓	34. Dizziness/tainting		✓			
14. Jaundice or hepatitis		✓	35. Epilepsy		✓			
15. Gall bladder disease		✓	36. Joints/spinal trouble		✓			
16. Marked change in bowel habits		✓	37. Surgical operation		✓			
17. Blood in stools (motions)		✓	38. Serious accident /fracture		✓			
18. Marked change in weight		✓	39. Tropical disease		✓			
19. Varicose veins		✓	40. Fear of heights		✓			
20. Lump in breast/armpit		✓	HAVE YOU EVER BEEN:-					
21. Cancer		✓	41. Rejected for employment or insurance for medical reasons					

How much tabacco each day? Non-smoker	Average daily alcohol consuption						
Family history	Diabetes <input type="checkbox"/>	Tuberculosis <input checked="" type="checkbox"/>	Epilepsy <input checked="" type="checkbox"/>	Asthama <input checked="" type="checkbox"/>	Eczerna <input type="checkbox"/>	Cancer <input checked="" type="checkbox"/>	Blood disease <input checked="" type="checkbox"/>
	Heart disease <input checked="" type="checkbox"/>	High blood pressure <input checked="" type="checkbox"/>		Stroke <input checked="" type="checkbox"/>			

PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT :-
I declare these statements to be true to the best of my knowledge and belief and I agree that the result of this medical in general terms may be revealed to the company if required, and the details sent to my own doctor if this is considered necessary by the examining medical officer.

Date 13.07.19 Signature of applicant

FOR COMPLETION BY EXAMINING DOCTOR OR SISTER
FURTHER DETAILS OF MEDICAL HISTORY AND RECREATIONAL ACTIVITIES

N - Normal A - Abnormal Please Describe		PHYSICAL EXAMINATION								
<input checked="" type="checkbox"/>	1. Eyes & Pupils	BMR - 31.1 kg/m ²								
<input checked="" type="checkbox"/>	2. E.N.T.	HR - 73b/min								
<input checked="" type="checkbox"/>	3. Teeth & Mouth									
<input checked="" type="checkbox"/>	4. Lungs & Chest									
<input checked="" type="checkbox"/>	5. Cardiovascular System									
<input checked="" type="checkbox"/>	6. Abdo. Viscera									
<input checked="" type="checkbox"/>	7. Hernial Orifices									
<input checked="" type="checkbox"/>	8. Anus & Rectum									
<input checked="" type="checkbox"/>	9. Genito - urinary									
<input checked="" type="checkbox"/>	10. Extremities									
<input checked="" type="checkbox"/>	11. Muscula-skeletal									
<input checked="" type="checkbox"/>	12. Skin & Varicose Vns.									
<input checked="" type="checkbox"/>	13. C.N.S.									
<input checked="" type="checkbox"/>	14. Breasts									
	15.									
HEIGHT cm	WEIGHT kg	B.P.	HEARING L R	HEARING L R	VISION: Uncorrected Corrected	DISTANT R L	NEAR R L	COLOUR VISION	BLOOD GROUP	
166	85.7	127/90								
N A		LABORATORY AND SPECIAL INVESTIGATIONS							N A	
		TC - 225 mg/dl SCr - 137 uL								6. Audiogram
		HDL - 38.19 mg/dl								7. Lung Function
		LDL - 139.64 mg/dl								8. Chest X-Ray
										9. Drug Screen
										10. CR Screen



OTHER FINDINGS (physique, scars, disabilities, mental stability etc.)

BMR - 31.1 kg/m²

SRKLE cell - Negative

Adv

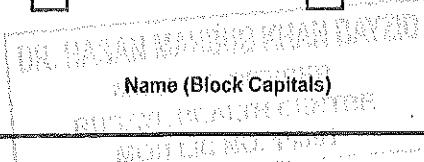
- Regular exercise
- Weight reduction
- Avoid high fat diet
- Repeat LFT after 3 months.

ASSESSMENT

FIT ALL AREAS FIT HOME SERVICES ONLY UNFIT/UNSUITABLE MAY BE REASSESSED

Date 04/07/09

Signature



Doctor / Sister

REVIEW/CONSULTATION

Date

Signature

Name (Block Capitals)

Doctor / Sister