



TRUCK OMAN

Annex 33- EX2 Form (Routine/Periodic Medical Examination)

## PERIODIC EXAMINATION REPORT (MEDICAL - CONFIDENTIAL)

Ident 1944N Reg.Dt 06/07/2023

Name HALWINDER SINGH

Development Oman  
DEPARTMENTSurname/  
Forenames BALWINDER SINGH

Gender Male Nationality INDIAN

PLEASE COMPLETE YOUR PERSONAL  
DETAILS IN BLOCK CAPITALS

Nationality INDIAN #DOB: 30/05/1973

Mobile No. 95503347

Address: 85409033

Company Number:

Reference Indicator:

## Personal Details

A ☒ Male ☐ Female☒ Married ☐ Single ☐ Separated /Divorced /Widow(er)

Home/Leave Address:

Relationship to employee

☐ Wife ☐ Son ☐ Daughter

No of Children: 2

Reason for Examination (tick as appropriate)

Periodic Medical Examination ☒Final / Retirement ☐Other Reason: ☐

## Employee only

B Present Job and Location: HD DRIVER 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, another 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, history of Hypertension	✓		
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 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: 06/07/23

Signature of Applicant:

Balwinder Singh





Appendix 33: EX2 Form (Routine/Periodic Medical Examination)

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

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.
169	80	28	130/90 mmhg
PULSE	HEARING	VISION	
92/min.	L N R N	DISTANT NEAR R L R L	
		Uncorrected Corrected	
		6/6 6/6	
Color Vision			
✓ Normal			
2. Abnormal			
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS	
✓		1. Urinalysis	
✓		2. Hb, Blood count, ESR	
✓		3. LFT, RFT, RBS	
✓		4. Drug Screen	
✓		5. Lipids (40 years +)	
✓		6. Sickie Cell test	
N	A	7. Audiogram	
		8. Lung Function	
		9. Chest X-Ray	
✓		10. ECG	
7.9		11. CVS risk for 40 yrs. & above	
		12. HIV, Hepatitis screening	
OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)			
Slightly heavy Abnormality Rhinic and webster's sound.			
ASSESSMENT AND RECOMMENDATIONS:			
<input checked="" type="checkbox"/> FIT ALL AREAS <input type="checkbox"/> FIT WITH RESTRICTION <input type="checkbox"/> TEMPORARY UNFIT <input type="checkbox"/> NFIT			
Date: <b>FIT</b> Name (Block Capitals): Dr. / Nurse			
Signature: <b>DR. SHAH FAISAL</b>			
REVIEW/CONSULTATION			
Date: Name (Block Capitals): Dr. / Nurse			
Signature:			

