



ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



**RUSAYL HEALTH CENTRE**  
ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Surname/Forenames		Ansah Sham Sudeen	36%
Nationality		Indian	Civil ID No. 79377948
Company Number:		Oran	Reference Indicator:

Mobile No. 96069803	Home/Leave Address:		
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Personal Details			
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A <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced /Widow(er)
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Home/Leave Address:	Relationship to employee	<input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	No of Children: 1
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Reason for Examination (tick as appropriate)			
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Periodic Medical Examination <input checked="" 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: Truck Driver Haima	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

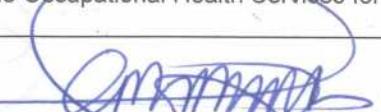
	N	Y	Description
Have you, since your last medical been treated by your family doctor or specialist for significant (major) ailments?	<input checked="" type="checkbox"/>		
1 Ear, nose, eye or throat problems	<input checked="" type="checkbox"/>		
2 Chest problems like asthma, bronchitis, other bad cough	<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?	<input checked="" type="checkbox"/>		
Do you smoke? If yes, what and how much each day?	<input checked="" type="checkbox"/>		
Do you drink alcohol? If yes, what is your average weekly intake?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	occasional drinker
Have you ever taken elicited/recreational drugs?	<input checked="" type="checkbox"/>		
Are you doing regular sports or physical activities?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	sometimes

**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.

October 5, 2011

Date:

Signature of Applicant:

  
DR. EUGENE R. LOPEZ  
MEDICAL OFFICER  
RUSAYL HEALTH CENTRE  
MOH LIC NO. 13458

COMPLETION BY EXAMINING DOCTOR OR NURSE

Other details of medical history and recreational activities

Name: Chamudeen

N = Normal A = Abnormal (please describe)		PHYSICAL EXAMINATION					
N	A						
✓		1. Eyes & Pupils		ERTL, pink palpebral conjunctiva			
✓		2. E.N.T.		Unremarkable			
✓		3. Teeth & Mouth		Dental Carrier			
✓		4. Lungs & Chest		SCE, clear BS RLF, O crackles			
✓		5. Cardiovascular System		Adequate precordium AB 5th LICS MCL O murmur			
✓		6. Abdo. Viscera		Flat abdomen, non-tender			
✓		7. Hernial Orifices		Unremarkable			
✓		8. Anus & Rectum		Unremarkable			
✓		9. Genito-urinary		Unremarkable			
✓		10. Extremities		Pulse Full and equal			
✓		11. Musculo-skeletal		No deformities			
✓		12. Skin & Varicose Vns.		No active skin lesions			
✓		13. C.N.S.		Unremarkable			
HEIGHT cm	WEIGHT kg	BMI	B.P. 125 81	PULSE 70/mins.	HEARING L (N) R (N)	VISION Frequency DISTANT NEAR Uncorrected R 6/6 L 6/6 Corrected R 6/6 L 6/6	
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. Sickle Cell test					12. HIV, Hepatitis screening

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

1. Improve diet and exercise regularly  
2. For repeat uric acid and lipid profile test after  
3 months

Overweight (BMI 26)  
Dyslipidemia

ASSESSMENT AND RECOMMENDATIONS:

FIT ALL AREAS  FIT WITH RESTRICTION  TEMPORARY UNFIT  UNFIT

Fit to work as  
HOD

October 5, 2021

DR. EUGENE LOPEZ

Date:

Name (Block Capitals): Dr. / Nurse

Signature:

REVIEW/CONSULTATION

Date:

Name (Block Capitals): Dr. / Nurse

Signature:



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MEDICAL OFFICER  
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