

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE
ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Mobile No.	78027894	Home/Leave Address:	India	Surname/Forenames	Pradeep Punarkha	
Personal Details		44y	DOB	1936	Nationality	Indian
			10/02/1978	123-116886455	Company Number:	Pradeep Punarkha
					Reference Indicator:	
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)			
Home/Leave Address:			<input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter		No of Children:	
Reason for Examination (tick as appropriate)						

Periodic Medical Examination Final / Retirement Other Reason:

Employee only

B Present Job and Location: India Next Job and Location: NIMR

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'

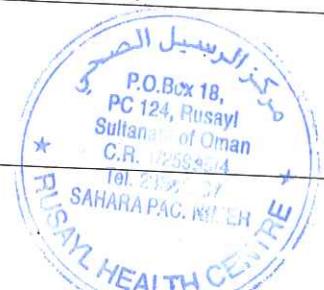
(yes) in the column. If 'Y' Please describe

		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, other 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			
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: 10/12/2022

Signature of Applicant:



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 167		WEIGHT kg 79	BMI 26	B.P. 126/86	PULSE 66/mins.	HEARING L R	Normal Normal Uncorrected Corrected	DISTANT R L	VISION R L	NEAR R L	
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS					N	A			
<input checked="" type="checkbox"/>		1. Urinalysis					<input checked="" type="checkbox"/>		7. Audiogram		
<input checked="" type="checkbox"/>		2. Hb, Bloodcount, ESR					<input checked="" type="checkbox"/>		8. Lung Function		
<input checked="" type="checkbox"/>		3. LFT, RFT, RBS					<input checked="" type="checkbox"/>		9. Chest X-Ray		
<input checked="" type="checkbox"/>		4. Drug Screen					<input checked="" type="checkbox"/>		10. ECG		
<input checked="" type="checkbox"/>		5. Lipids (40 years +)					<input checked="" type="checkbox"/>		11. CVS risk for 40 yrs. & above		
<input checked="" type="checkbox"/>		6. Sickle Cell test					<input checked="" type="checkbox"/>		12. HIV, Hepatitis screening		

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

NAD

ASSESSMENT AND RECOMMENDATIONS:

FIT ALL AREAS FIT WITH RESTRICTION TEMPORARY UNFIT UNFIT

DR. SANATH BUDDHIKA PRIYADARSHAN

GENERAL PRACTITIONER
RUSAYL HEALTH CENTRE

REG. NO. 16042

10/12/2022

Date: Name (Block Capitals): Dr. / Nurse

Signature:

REVIEW/CONSULTATION

Date: Name (Block Capitals): Dr. / Nurse

Signature:

