

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



Surname/Forenames: Jaswinder Singh  
Nationality: Harjeet  
Tuzan  
Company Number: 1940 Reference Indicator: JVarkhman

Mobile No: 94033092 Home/Leave Address: Dung  
Personal Details: 429 Dob: 27/07/1980 ID: 88571928

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

Home/Leave Address: Relationship to employee  
 Wife  Son  Daughter No of Children:

Reason for Examination (tick as appropriate)

Periodic Medical Examination  Final / Retirement  Other Reason:

Employee only

B Present Job and Location: HOD 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.

09/01/2023

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	WEIGHT kg	BMI	B.P.	PULSE 60 mins.	HEARING L: <i>Normal</i> R: <i>Normal</i> Uncorrected Corrected	DISTANT R: <i>6/6</i> L: <i>6/6</i>	VISION NEAR R: <i>6/6</i> L: <i>6/6</i>				
172	89	30	129/82								

N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS		N	A	
<input checked="" type="checkbox"/>		1. Urinalysis				7. Audiogram
<input checked="" type="checkbox"/>		2. Hb, Bloodcount, ESR				8. Lung Function
<input checked="" type="checkbox"/>		3. LFT, RFT, RBS				9. Chest X-Ray
<input checked="" type="checkbox"/>		4. Drug Screen				10. ECG
<input checked="" type="checkbox"/>		5. Lipids (40 years +)				11. CVS risk for 40 yrs. & above
<input checked="" type="checkbox"/>		6. Sickle Cell test				12. HIV, Hepatitis screening

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

A 2 riser on 10 or fat 2.0A.  
weight 70 nutrition, regular exercise

ASSESSMENT AND RECOMMENDATIONS:

FIT ALL AREAS  FIT WITH RESTRICTION  TEMPORARY UNFIT  UNFIT

GENERAL PRACTITIONER  
RUSAYL HEALTH CENTRE  
MOH LIC NO. 16042

Date: 09/01/2023 Name (Block Capitals): Dr. / Nurse

Signature:

REVIEW/CONSULTATION

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

Signature:

