

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE

ISO 9001-2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Surname/
Forenames

Manohar Singh

Nationality

Indian

Mobile No. 79005739

Home/Leave Address: 21 Ling

Company Number: 1939

Reference Indicator:

Personal Details

41y 1 D.O.B. 27,04,1981 / T 0 - 116960491

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:

Next Job and Location:

HDD

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.

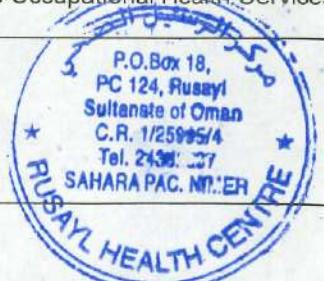
Please answer the following questions and tick 'N' (no) or 'Y' (yes) in the column. If 'Y' Please describe

	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.

07/01/2023

Manohar Singh
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 mins.	HEARING L R	VISION DISTANT R L	VISION NEAR R L
164	77	29	126/84	68	N / R / Uncorrected Corrected	6/6	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.)

Adviser on weight reduction,
Low fat diet, regular exercise, to visit family

ASSESSMENT AND RECOMMENDATIONS:

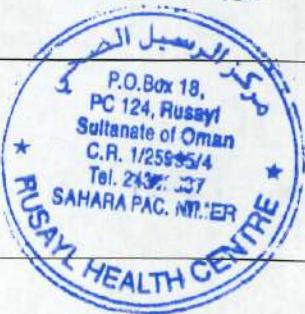
FIT ALL AREAS FIT WITH RESTRICTION TEMPORARY UNFIT UNFIT

121 Vari th
FCP 1/LFT after
03 months

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

REVIEW/CONSULTATION

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



Fitness to Work Certificate for drivers

Employee Data		Date: 07/01/2023													
Name : Mansoor Singh		Department/Company : Trukuman													
I.D. No: 116960491	Age: 41y	Occupation : H.D.D													
Type of Medical Evaluation		Mark those applying ✓													
A5- HVD- Crane or forklift driving & all heavy vehicles		A7- Professional driving-light vehicles													
<p>Health Advisor Statement: The above named person has been examined according to the statements laid down in "Protocols and Guidance Notes on the Medical Evaluation of Fitness to Work". At this time his/her fitness to work status for the above tasks is as follows.</p>															
Fit with no restrictions		✓													
<p>Fit with following restriction(s)</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 45%; padding: 5px;">The employee is fit for above work but should avoid the following task(s)</td> <td style="width: 25%; padding: 5px; text-align: center;">Temporary restriction</td> <td style="width: 25%; padding: 5px; text-align: center;">Permanent restriction</td> </tr> <tr> <td style="padding: 5px;">Work near moving machinery or sharp edges</td> <td style="padding: 5px; text-align: center;"> </td> <td style="padding: 5px; text-align: center;"> </td> </tr> <tr> <td style="padding: 5px;">Operate Heavy motor vehicles, forklifts or heavy machinery</td> <td style="padding: 5px; text-align: center;"> </td> <td style="padding: 5px; text-align: center;"> </td> </tr> <tr> <td style="padding: 5px;">Other (Specify)</td> <td style="padding: 5px; text-align: center;"> </td> <td style="padding: 5px; text-align: center;"> </td> </tr> </table>				The employee is fit for above work but should avoid the following task(s)	Temporary restriction	Permanent restriction	Work near moving machinery or sharp edges			Operate Heavy motor vehicles, forklifts or heavy machinery			Other (Specify)		
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Work near moving machinery or sharp edges															
Operate Heavy motor vehicles, forklifts or heavy machinery															
Other (Specify)															
<p>Temporary Unfit until</p>															
<p>Permanently Unfit</p>															
Name of health advisor	Signature		Date: 07/01/2023												

