



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

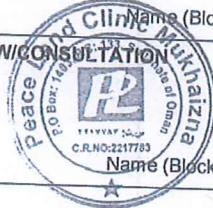
		PHYSICAL EXAMINATION										
N	A											
✓	1. Eyes & Pupils											
✓	2. E.N.T.											
✓	3. Teeth & Mouth											
✓	4. Lungs & Chest											
✓	5. Cardiovascular System											
✓	6. Abdo. Viscera											
✓	7. Hernial Orifices											
✓	8. Anus & Rectum											
✓	9. Genito-urinary											
✓	10. Extremities											
✓	11. Musculo-skeletal											
✓	12. Skin & Varicose Vns.											
✓	13. C.N.S.											
HEIGHT cm 163		WEIGHT kg 79	BMI 29.7	B.P. 120 80 mmhg	PULSE 62/mins.	HEARING L ~ R ~	VISION DISTANT Uncorrected Corrected R L R L 6/6 6/6				NEAR	Color Vision 1. Normal 2. Abnormal
N A		LABORATORY AND OTHER SPECIAL INVESTIGATIONS				N	A					
✓	1. Urinalysis				✓	✓	7. Audiogram					
✓	2. Hb, Blood count, 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.)

ASSESSMENT AND RECOMMENDATIONS:

FIT ALL AREAS FIT WITH RESTRICTION TEMPORARY UNFIT UNFIT

Date:



Name (Block Capitals): Dr. / Nurse

DR. FARZAD FARHAD ABBASMANESH
GENERAL PRACTITIONER
M.O.H LICENSE NO.20379

Signature:

Date:

Name (Block Capitals): Dr. / Nurse

Signature:



30/01/2023	Reg'Dt	INDIAN
16103	AJAYKUMAR VALTHARA	Nationality
Male	Nationality	
Petroleum Development Oman MEDICAL DEPARTMENT		
PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS		
Mobile No.	71021399	Address:
103214309		
Surname/Forenames		
AJAY KUMAR VALTHARA		
Nationality INDIAN - DOB - 04/03/1973		
Company Number: 1945 Reference Indicator:		
Personal Details		
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:		Relationship to employee <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter
No of Children: 2		
Reason for Examination (tick as appropriate)		
Periodic Medical Examination <input checked="" type="checkbox"/> Final / Retirement <input type="checkbox"/> Other Reason: <input type="checkbox"/>		
Employee only		
B Present Job and Location: Driver - Haima		Next Job and Location:
Are you a registered person with special needs? <input type="checkbox"/>		Do you belong to any Medical Insurance Scheme? <input type="checkbox"/>
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, another 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 ,history of Hypertension	<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?		
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:	30 - 01 - 2023	
Signature of Applicant:		

