



1004-01
TON-01

ECG

Appendix 33: EX2 Form (Routine/Periodic Medical Examination)
ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL - CONFIDENTIAL)

Client 19330 Reg.Dt 19 06 2023

Name SANTHOSH PAKKALLICHIRAYIL

Gender Male Nationality INDIAN

Ministry of Health
Medical Department

Surname/
Forenames SANTHOSH PAKKALLICHIRAYIL

Nationality INDIAN - D.O.B # 23-04-75

Company Number: 6457 Reference Indicator:

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Mobile No. 95872753 Address: 72708409

Personal Details

A ☒ Male ☐ Female

☒ Married ☐ Single ☐ Separated /Divorced /Widow(er)

Home/Leave Address:

Relationship to employee

☐ Wife ☐ Son ☐ Daughter No of Children: 2

Reason for Examination (tick as appropriate)

Periodic Medical Examination ☒

Final / Retirement ☐

Other Reason: ☐

Employee only

B Present Job and Location:

WELDER - MAINA

Next Job and Location:

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, another 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, history of Hypertension | ✓ | | |
| 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 dependents 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 illicit/recreational drugs? | ✓ | | |
| Are you doing regular sports or physical activities? | ✓ | | WALKING |

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: 19-06-2023

Signature of Applicant: ✓

[Signature]





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 | | | | | | | | | |
| N = Normal A = Anormal (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. Hemial 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 | HEARING | VISION | | Color Vision | |
| 166 | 71 | 25.8 | 130/90 | 74/min. | L N R N | DISTANT R L | NEAR R L | 1. Normal 2. Abnormal | |
| | | | | | Uncorrected Corrected | 6/6 6/6 | | | |
| 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 +) | | | | 6.7 | | 11. CVS risk for 40 yrs. & above | |
| ✓ | | 6. Sickie Cell test | | | | | | 12. HIV, Hepatitis screening | |
| OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.) | | | | | | | | | |
| L L sm (Lungs Exercise, diet) | | | | | | | | | |
| ASSESSMENT AND RECOMMENDATIONS: | | | | | | | | | |
| <input checked="" type="checkbox"/> FIT ALL AREAS <input type="checkbox"/> FIT WITH RESTRICTION <input type="checkbox"/> TEMPORARY UNFIT <input type="checkbox"/> UNFIT | | | | | | | | | |
| Date: 20, 6, 23 | | Name (Block Capitals): Dr. / Nurse | | Dr. Shima Ayed Abdollah Jafar Cardiologist Specialist MOH No. 21982 | | Signature: | | | |
| REVIEW/CONSULTATION | | | | | | | | | |
| Date: Name (Block Capitals): Dr. / Nurse Signature: | | | | | | | | | |

