

# 6460

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS



رئاسة الصحة  
RUSAYL HEALTH CENTRE  
NIR, FAHUD, QARNALAY, BHAJA, SAHRWAL, MARFUL

## INITIAL EXAMINATION REPORT

Place of examination **RS PAC CLINIC BHAJA** Date **02/07/19** DOB: **03/01/1969, CML-66986995, STAR-6460**  
Home Telephone number **93858657**

If a dependant or fiancee entr employees name jere :-

Surname:

Forenames:

	Nationality <b>INDIAN</b>	Country of birth <b>INDIA</b>	Religion <b>HINDUISM</b>
<input checked="" type="checkbox"/> Male	<input type="checkbox"/> Single	<input type="checkbox"/> Widow(er)	Relationship to employee
<input checked="" type="checkbox"/> Female	<input checked="" type="checkbox"/> Married	<input type="checkbox"/> Divorced Separated	<input checked="" type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Fiancee
Number of Children <b>2</b>			

Reason for examination  Pre-employment  
 Pre-overseas

Job :- **DRIVER (HEAVY)**Area:- **BHAJA**

Name and address of family doctor

List your last 3 jobs

(1)

(2)

(3)



Are you Registered Disabled Person? (UK)

 Do you belong to any Medical Insurance Scheme? 

DO YOU HAVE OR HAVE YOU HAD :- (Tick "yes" or "No" column or put a (?) It uclerain exclude minor ailmenis.)

	Y	N		Y	N		Y	N
1. Sirius rouble		<input checked="" type="checkbox"/>	22. Heart Disease		<input checked="" type="checkbox"/>	42. Awarded benifities for Industrial injury/lilness		<input checked="" type="checkbox"/>
2. Neck swellings/flands		<input checked="" type="checkbox"/>	23. Rheumatic Fever		<input checked="" type="checkbox"/>	43. Treated for a mental condition. eg . depression		<input checked="" type="checkbox"/>
3. Difficulty in vision		<input checked="" type="checkbox"/>	24. Abnormal heartbeat		<input checked="" type="checkbox"/>	44. Treated for problem drinking or drug abuse		<input checked="" type="checkbox"/>
4. Any ear discharge		<input checked="" type="checkbox"/>	25. High blood pressure		<input checked="" type="checkbox"/>	45. Exposed to toxic substance or noise		<input checked="" type="checkbox"/>
5. Asthma/bronchitis		<input checked="" type="checkbox"/>	26. Stroke		<input checked="" type="checkbox"/>	FOR WOMEN ONLY		
6. Hayfever/other allergy		<input checked="" type="checkbox"/>	27. Serious chest pain		<input checked="" type="checkbox"/>	Have you ever had:-		
7. Any skin trouble		<input checked="" type="checkbox"/>	28. Any blood disease		<input checked="" type="checkbox"/>	46. An abnormal smear		
8. Tuberculosis		<input checked="" type="checkbox"/>	29. Kidney disease		<input checked="" type="checkbox"/>	47. Any gynaecological treatment		
9. Shortness of breath		<input checked="" type="checkbox"/>	30. Painful passage of urine		<input checked="" type="checkbox"/>	48. Are you pregnant?		
10. Coughed/vomited blood		<input checked="" type="checkbox"/>	31. Blood in urine		<input checked="" type="checkbox"/>	49. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE ?		
11. Severe abdominal pain		<input checked="" type="checkbox"/>	32. Diabetes		<input checked="" type="checkbox"/>			
12. Stomach ulcer		<input checked="" type="checkbox"/>	33. Headaches /migraine		<input checked="" type="checkbox"/>			
13. Recurrent indigestion		<input checked="" type="checkbox"/>	34. Dizziness/tainting		<input checked="" type="checkbox"/>			
14. Jaundice or hepatitis		<input checked="" type="checkbox"/>	35. Epilepsy		<input checked="" type="checkbox"/>			
15. Gall bladder disease		<input checked="" type="checkbox"/>	36. Joints/spinal trouble		<input checked="" type="checkbox"/>			
16. Marked change in bowel habits		<input checked="" type="checkbox"/>	37. Surgical operation		<input checked="" type="checkbox"/>			
17. Blood in stools (motions)		<input checked="" type="checkbox"/>	38. Serious accident /fracture		<input checked="" type="checkbox"/>			
18. Marked change in weight		<input checked="" type="checkbox"/>	39. Tropical disease		<input checked="" type="checkbox"/>			
19. Varicose veins		<input checked="" type="checkbox"/>	40. Fear of heights		<input checked="" type="checkbox"/>			
20. Lump in breast/armpit		<input checked="" type="checkbox"/>	HAVE YOU EVER BEEN:-					
21. Cancer		<input checked="" type="checkbox"/>	41. Rejected for employment or insurance for medical reasons					

How much tabacco each day? **Non-smoker**Average daily alcohol consuption **NO**

Family history	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Asthma	<input type="checkbox"/> Eczema
	<input checked="" type="checkbox"/> Heart disease	<input checked="" type="checkbox"/> High blood pressure	<input checked="" type="checkbox"/> Stroke	<input checked="" type="checkbox"/> Cancer	<input checked="" type="checkbox"/> Blood disease

PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT:-

I declare these statements to be true to the best of my knowledge and belief and I agree that the result of this medical in general terms may be revealed to the company if required, and the details sent to my own doctor if this is considered necessary by the examining medical officer.

Date **02-07-19**

Signature of applicant

FOR COMPLETION BY EXAMINING DOCTOR OR SISTER  
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. Muscula-skeletal
✓		12. Skin & Varicose Vns.
✓		13. C.N.S.
✓		14. Breasts
		15.

B.M.F - 32.6 kg/m<sup>2</sup>  
HR - 73b/min



HEIGHT cm	WEIGHT kg	B.P.	HEARING L	HEARING R	VISION: Uncorrected	DISTANT R L	NEAR R L	COLOUR VISION	BLOOD GROUP
169	87.6	133/77	R	R	Corrected	R L	R L		

N	A	LABORATORY AND SPECIAL INVESTIGATIONS	N	A
✓		FBS - 112 mg/dl		6. Audiogram
✓		TC - 208 mg/dl		7. Lung Function
✓		HDL - 38.24 mg/dl		8. Chest X-Ray
✓		LDL - 138 mg/dl		9. Drug Screen
				10. CR Screen
✓		5. E.C.G.		

OTHER FINDINGS (physique, scars, disabilities, mental stability etc.)

B.M.F - 32.6 kg/m<sup>2</sup>

SICKLE cell - Negative

• TMT is negative for ischaemia

ABN

- Regular exercise
- Weight reduction
- Avoid high fat diet
- Repeat FBS to exclude DM

ASSESSMENT

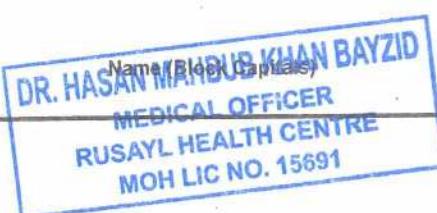
FIT ALL AREAS  FIT HOME SERVICES ONLY  UNFIT/UNSUITABLE  MAY BE REASSESSED

Date 02-07-19

  
Signature

Doctor / Sister

REVIEW/CONSULTATION



Date

Signature

Name (Block Capitals)

Doctor / Sister