



MEDICAL EXAMINATION REPORT (CONFIDENTIAL)

#6998

PLEASE COMPLETE YOUR PERSONAL  
DETAILS IN BLOCK CAPITALS

Surname <b>Salem MUSLEM AL HANDI</b>		Forenames <b>HAMOOD AL SULAIMI</b>		Address <b>12327199 - Tawek Oman</b>		Home telephone number <b>93555719</b>	
Place of examination <b>my</b>		Date <b>1/6/20</b>					
If a dependant enter employee's name here: Surname:				Forenames:			
Birth date <b>21/5/99</b>		Nationality <b>Omani</b>		Country of birth <b>Oman</b>		Religion:	
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Married <input checked="" type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced		Relationship to employee <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter		Number of children:	
Reason for examination		Pre-Employment <input type="checkbox"/> Periodic medical check-up <input type="checkbox"/>		Job <b>Driver</b>		Area:	
Pre-Overseas <input type="checkbox"/>							
Name and address of family doctor				List your last 3 jobs			
				(1)			
				(2)			
				(3)			
Are you a Registered Disabled Person? (UK only) <input type="checkbox"/>				Do you belong to any Medical Insurance Scheme? <input type="checkbox"/>			
DO YOU HAVE OR HAVE YOU HAD:- (Tick "Yes" or "No" column or put a (?) if uncertain exclude minor ailments.)							
Y		N		Y		N	
1. Sinus trouble		<input checked="" type="checkbox"/>		21. Cancer		<input checked="" type="checkbox"/>	
2. Neck swelling/glands		<input checked="" type="checkbox"/>		22. Heart Disease		<input checked="" type="checkbox"/>	
3. Difficulty in vision		<input checked="" type="checkbox"/>		23. Rheumatic fever		<input checked="" type="checkbox"/>	
4. Any ear discharge		<input checked="" type="checkbox"/>		24. Abnormal heartbeat		<input checked="" type="checkbox"/>	
5. Asthma/bronchitis		<input checked="" type="checkbox"/>		25. High blood pressure		<input checked="" type="checkbox"/>	
6. Hayfever /other significant allergy		<input checked="" type="checkbox"/>		26. Stroke		<input checked="" type="checkbox"/>	
7. Any skin trouble		<input checked="" type="checkbox"/>		27. Serious chest pain		<input checked="" type="checkbox"/>	
8. Tuberculosis		<input checked="" type="checkbox"/>		28. Any blood disease		<input checked="" type="checkbox"/>	
9. Shortness of breath		<input checked="" type="checkbox"/>		29. Kidney disease		<input checked="" type="checkbox"/>	
10. Coughed/vomited blood		<input checked="" type="checkbox"/>		30. Blood in urine		<input checked="" type="checkbox"/>	
11. Severe abdominal pain		<input checked="" type="checkbox"/>		31. Painful passage of urine		<input checked="" type="checkbox"/>	
12. Stomach ulcer		<input checked="" type="checkbox"/>		32. Diabetes		<input checked="" type="checkbox"/>	
13. Recurrent indigestion		<input checked="" type="checkbox"/>		33. Headaches/migraine		<input checked="" type="checkbox"/>	
14. Jaundice or hepatitis		<input checked="" type="checkbox"/>		34. Dizziness/fainting		<input checked="" type="checkbox"/>	
15. Gall Bladder disease		<input checked="" type="checkbox"/>		35. Epilepsy		<input checked="" type="checkbox"/>	
16. Marked change in bowel habits		<input checked="" type="checkbox"/>		36. Joints/spinal trouble		<input checked="" type="checkbox"/>	
17. Blood in stools (motions)		<input checked="" type="checkbox"/>		37. Surgical operation		<input checked="" type="checkbox"/>	
18. Marked change in weight		<input checked="" type="checkbox"/>		38. Serious accident/fracture		<input checked="" type="checkbox"/>	
19. Varicose veins		<input checked="" type="checkbox"/>		39. Tropical disease		<input checked="" type="checkbox"/>	
20. Lump in breast/arm/pit		<input checked="" type="checkbox"/>		40. Fear of heights		<input checked="" type="checkbox"/>	
How much tobacco each day? <b>NO</b>				Average daily alcohol consumption <b>NO</b>			
Have you ever taken elicited drugs? ( )							
FAMILY HISTORY: Diabetes ( ) Tuberculosis ( ) Epilepsy ( ) Asthma ( ) Eczema ( )							
Heart disease ( ) High blood pressure ( ) Stroke ( ) Blood Disease ( ) Cancer ( )							
PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT:-							
I declared these statements to be true to the best of my knowledge and belief and I agree that the result of this medical examination 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: <b>31/5/20</b>				Signature of Applicant: <b>[Signature]</b>			