

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



**RUSAYL HEALTH CENTRE**  
ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Mobile No. 98463564	Home/Leave Address: TRUCK OMAN	Surname/Forenames NISHAD PARAPURATH
Personal Details DOB: 20/05/82		Nationality INDIAN (ID NO: 79579868)
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

Company Number: Reference Indicator:

AGE: 38 yrs

Reason for Examination (tick as appropriate)

Periodic Medical Examination  Final / Retirement  Other Reason:

Employee only

B Present Job and Location: OMAN ALAN ELECTRICIAN 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?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
1 Ear, nose, eye or throat problems	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
2 Chest problems like asthma, bronchitis, other bad cough	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
3 Heart abnormality, chest pains	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
4 Abdominal pains, abnormal bowel motions	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
5 Urogenital problems (kidney disease, menstrual disorder)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
6 Skin trouble or allergies	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
7 Epileptic fits, dizzy spells or migraine	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
8 History of mental illness, depression anxiety	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
9 Diabetes, thyroid disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
10 Blood disorder e.g. anaemia, blood cancer e.g. leukaemia	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
11 Any history of accidents or fractures	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
12 Have you had any serious allergies	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
13 Do any dependants have a significant ongoing illness?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
14 Any family history of cancers	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Do you take any regular medicines, or have you taken in the past?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Lifexon 10/10mg 58
Do you smoke? If yes, what and how much each day?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Do you drink alcohol? If yes, what is your average weekly intake?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Have you ever taken elicited/recreational drugs?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Are you doing regular sports or physical activities?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	

**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: 25/12/20

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	HTN										
	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	(N)	DISTANT R L	NEAR R L	VISION			
177.5	84	26.7	190 140	71	R	Uncorrected Corrected	6/6 6/6	NN	Color vision			

N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A
✓	1. Urinalysis	RBS = 105 mg/dl		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.)

## ASSESSMENT AND RECOMMENDATIONS:

### FIT ALL AREAS

FIT WITH RESTRICTION

TEMPORARY UNFIT

UNFIT

Date: 17/01/21

Name (Block Capitals): Dr. / Nurse

DR. JUDE NNAMDI UGWUJA  
GENERAL PRACTITIONER  
s): Dr / Nurse  
RSAYL HEALTH CENTRE  
MOH LIC NO 18259

Signature:

## **REVIEW/CONSULTATION**

RP: 139 somtg

Date: 12/8/21

Name (Block Capitals): Dr. / Nurse

Signature:

Hannu

Rusayl Industrial Estate  
P.O. Box : 18, Rusayl  
Postal Code : 124  
Sultanate of Oman  
Tel.: 24446151 / 54  
Fax : 24446833



Timing : O.P.D. 7 a.m. to 5. p.m.

Date : 20/12/2020

## LABORATORY INVESTIGATION

Name : <u>Nishad . P.</u>	Sex : <u>M</u> Age : <u>38</u>																																																												
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