

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE

ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Surname/ Forenames <i>Hamood, Mohsin</i>																																																																	
Nationality <i>Al Qani</i> <i>Omani</i>																																																																	
Mobile No: <i>98998743</i> Home/Leave Address: <i>Nizwa</i>																																																																	
Company Number: <i>10447</i> Reference Indicator: <i>Trukhman</i>																																																																	
Personal Details <i>41y 1 Darb + 16, 10, 1982 111-12 522024</i>																																																																	
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: <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter      No of Children:																																																																	
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: <i>HOH</i> Next Job and Location: <i>PDO Area</i>																																																																	
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																																																																	
<table border="1"> <thead> <tr> <th></th> <th>N</th> <th>Y</th> <th>Description</th> </tr> </thead> <tbody> <tr> <td>Have you, since your last medical been treated by your family doctor or specialist for significant (major) ailments?</td> <td></td> <td></td> <td></td> </tr> <tr> <td>1 Ear, nose, eye or throat problems</td> <td></td> <td></td> <td></td> </tr> <tr> <td>2 Chest problems like asthma, bronchitis, other bad cough</td> <td></td> <td></td> <td></td> </tr> <tr> <td>3 Heart abnormality, chest pains</td> <td></td> <td></td> <td></td> </tr> <tr> <td>4 Abdominal pains, abnormal bowel motions</td> <td></td> <td></td> <td></td> </tr> <tr> <td>5 Urogenital problems (kidney disease, menstrual disorder)</td> <td></td> <td></td> <td></td> </tr> <tr> <td>6 Skin trouble or allergies</td> <td></td> <td></td> <td></td> </tr> <tr> <td>7 Epileptic fits, dizzy spells or migraine</td> <td></td> <td></td> <td></td> </tr> <tr> <td>8 History of mental illness, depression anxiety</td> <td></td> <td></td> <td></td> </tr> <tr> <td>9 Diabetes, thyroid disease</td> <td></td> <td></td> <td></td> </tr> <tr> <td>10 Blood disorder e.g. anaemia, blood cancer e.g. leukaemia</td> <td></td> <td></td> <td></td> </tr> <tr> <td>11 Any history of accidents or fractures</td> <td></td> <td></td> <td></td> </tr> <tr> <td>12 Have you had any serious allergies</td> <td></td> <td></td> <td></td> </tr> <tr> <td>13 Do any dependants have a significant ongoing illness?</td> <td></td> <td></td> <td></td> </tr> <tr> <td>14 Any family history of cancers</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>			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, other 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				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 dependants have a significant ongoing illness?				14 Any family history of cancers			
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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: <i>07/05/2023</i> Signature of Applicant: <i>[Signature]</i>																																																																	

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
		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 b/mins.	HEARING L Normal R Normal Uncorrected Corrected	DISTANT R 6/6 L 6/6	VISION NEAR R 6/6 L 6/6
159	114	45	124/86	64			

N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A
✓		1. Urinalysis	✓	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.)

A advised on oral care and diet, low fat diet, regular exercise, status for 03 m, repeat Fd p after 03 months.

ASSESSMENT AND RECOMMENDATIONS:

FIT ALL AREAS  FIT WITH RESTRICTION  TEMPORARY UNFIT  UNFIT

03 months.

DR. SANATH BUDDHIKA PRIYADARSHAN  
GENERAL PRACTITIONER  
RUSAYL HEALTH CENTRE

Date: 07/05/2023

Name (Block Capitals): Dr. / Nurse



REVIEW/CONSULTATION

Date:

Name (Block Capitals): Dr. / Nurse

Signature: