



Appendix 33: EX2 Form (Routine/Periodic Medical Examination)

MEDICAL – CONFIDENTIAL

1KUCKOMXN

19547 Reg. Dt 13/07/2023

SRINIVAS SANABINA

Male Nationality INDIAN

n Development Oman
MEDICAL DEPARTMENTPLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Mobile No. 97058942

Address: 78669049

Surname/
Forenames SRINIVAS SANABINA

Nationality INDIAN #DOB: 16/05/1983

Company Number:

Reference Indicator:

Personal Details

A Male Female Married Single Separated /Divorced /Widow(er)

Home/Leave Address:

 Wife Son Daughter

No of Children: 1

Reason for Examination (tick as appropriate)

Periodic Medical Examination Final / Retirement Other Reason:

Employee only

B Present Job and Location: CO-ORDINATOR 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 dependants 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 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: 13/07/2023

Signature of Applicant: 



Appendix 33: EX2 Form (Routine/Periodic Medical Examination)

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL - CONFIDENTIAL)

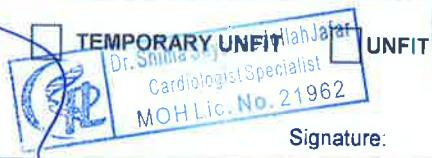
FOR COMPLETION BY EXAMINING DOCTOR OR NURSE

Further details of medical history and recreational activities

N = Normal A = 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 170	WEIGHT kg 50	BMI 17.3	B.P. 120 70 mmhg	PULSE 66 /mins.	HEARING L N R N	VISION DISTANT R L Uncorrected 6/6 Corrected 6/6	NEAR R L	Color Vision	
								✓ 1. Normal	2. Abnormal
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 +)				✓	3-9	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

Date: 13/7/23 Name (Block Capitals): Dr. / Nurse

Signature:



REVIEW/CONSULTATION

Date:

Name (Block Capitals): Dr. / Nurse

Signature: