

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE
ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Surname/ Forenames		ZAHEER ABBAS (31 yrs)
Nationality		PAKISTANI

Mobile No. 9514 6455	Home/Leave Address:	Company Number: 1958	Reference Indicator:
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Personal Details DDB- 06/04/1990

A <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married <input checked="" type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced /Widow(er)
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Home/Leave Address: HAFZABAD PAKISTAN	Relationship to employee <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	No of Children: NA
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Reason for Examination (tick as appropriate)

Periodic Medical Examination <input checked="" type="checkbox"/>	Final / Retirement <input type="checkbox"/>	Other Reason: <input type="checkbox"/>
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Employee only

B Present Job and Location: DRIVER HEAVY, TRUCKMAN.	Next Job and Location:
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Are you a registered person with special needs? <input type="checkbox"/>	Do you belong to any Medical Insurance Scheme? <input type="checkbox"/>
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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	<input checked="" type="checkbox"/>		
2 Chest problems like asthma, bronchitis, other bad cough	<input checked="" type="checkbox"/>		
3 Heart abnormality, chest pains	<input checked="" type="checkbox"/>		
4 Abdominal pains, abnormal bowel motions	<input checked="" type="checkbox"/>		
5 Urogenital problems (kidney disease, menstrual disorder)	<input checked="" type="checkbox"/>		
6 Skin trouble or allergies	<input checked="" type="checkbox"/>		
7 Epileptic fits, dizzy spells or migraine	<input checked="" type="checkbox"/>		
8 History of mental illness, depression anxiety	<input checked="" type="checkbox"/>		
9 Diabetes, thyroid disease	<input checked="" type="checkbox"/>		
10 Blood disorder e.g. anaemia, blood cancer e.g. leukaemia	<input checked="" type="checkbox"/>		
11 Any history of accidents or fractures	<input checked="" type="checkbox"/>		
12 Have you had any serious allergies	<input checked="" type="checkbox"/>		
13 Do any dependants have a significant ongoing illness?	<input checked="" type="checkbox"/>		
14 Any family history of cancers	<input checked="" type="checkbox"/>		

Do you take any regular medicines, or have you taken in the past?

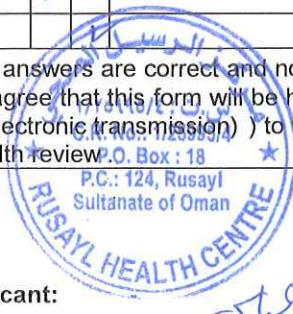
Do you smoke? If yes, what and how much each day? 10 sticks / day

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. P.O. Box : 18



Date: 08-05-2021	Signature of Applicant: <i>St. S. A.</i>
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FOR COMPLETION BY EXAMINING DOCTOR OR NURSE

Further details of medical history and recreational activities

ZAHEER ABBAS (38 yrs)

N = Normal A = Abnormal (please describe)		PHYSICAL EXAMINATION						
N	A							
<input checked="" type="checkbox"/>	1. Eyes & Pupils							
<input checked="" type="checkbox"/>	2. E.N.T.							
<input checked="" type="checkbox"/>	3. Teeth & Mouth	Lost teeth - 3						
<input checked="" type="checkbox"/>	4. Lungs & Chest							
<input checked="" type="checkbox"/>	5. Cardiovascular System							
<input checked="" type="checkbox"/>	6. Abdo. Viscera							
<input checked="" type="checkbox"/>	7. Hernial Orifices							
<input checked="" type="checkbox"/>	8. Anus & Rectum							
<input checked="" type="checkbox"/>	9. Genito-urinary							
<input checked="" type="checkbox"/>	10. Extremities							
<input checked="" type="checkbox"/>	11. Musculo-skeletal							
<input checked="" type="checkbox"/>	12. Skin & Varicose Vns.							
<input checked="" type="checkbox"/>	13. C.N.S.							
HEIGHT cm	WEIGHT kg	BMI	B.P. mm Hg	PULSE /mins.	HEARING L N R N	VISION		
168	50	17.71	110 70 mm Hg	84	Uncorrected Corrected	DISTANT R L	NEAR R L	
<input checked="" type="checkbox"/>	1. Urinalysis	7. Audiogram						
<input checked="" type="checkbox"/>	2. Hb, Bloodcount, ESR	8. Lung Function						
<input checked="" type="checkbox"/>	3. LFT, RFT, RBS FBS	9. Chest X-Ray						
<input checked="" type="checkbox"/>	4. Drug Screen	10. ECG						
<input checked="" type="checkbox"/>	5. Lipids (40 years +)	11. CVS risk for 40 yrs. & above						
<input checked="" type="checkbox"/>	6. Sickle Cell test	12. HIV, Hepatitis screening						
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS				N	A	
<input checked="" type="checkbox"/>	1. Urinalysis	- Not done - Negative				<input checked="" type="checkbox"/>		7. Audiogram
<input checked="" type="checkbox"/>	2. Hb, Bloodcount, ESR					<input checked="" type="checkbox"/>		8. Lung Function
<input checked="" type="checkbox"/>	3. LFT, RFT, RBS FBS					<input checked="" type="checkbox"/>		9. Chest X-Ray
<input checked="" type="checkbox"/>	4. Drug Screen					<input checked="" type="checkbox"/>		10. ECG
<input checked="" type="checkbox"/>	5. Lipids (40 years +)					<input checked="" type="checkbox"/>		11. CVS risk for 40 yrs. & above
<input checked="" type="checkbox"/>	6. Sickle Cell test					<input checked="" type="checkbox"/>		12. HIV, Hepatitis screening

OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)

• Smoker - [10 sticks/day]. Underweight [BMI = 17.71 Kg/m²].

• Lost teeth - 3

• No other physical or mental abnormality found.

ASSESSMENT AND RECOMMENDATIONS:

FIT ALL AREAS FIT WITH RESTRICTION TEMPORARY UNFIT UNFIT

09-05-2021

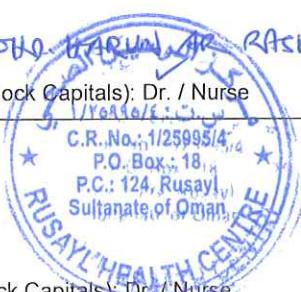
DR. MOHAMMAD HARUN AR RASHID

Date:

Name (Block Capitals): Dr. / Nurse

Signature:

REVIEW/CONSULTATION



Date:

Name (Block Capitals): Dr. / Nurse

DR. MOHAMMAD HARUN AR RASHID

MEDICAL OFFICER
RUSAYL HEALTH CENTRE
MOH LIC NO. 555

Signature: