

6623

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS



RUSAYL HEALTH CENTRE
NIMR, FAHUD, QARNALAY, BHAJA, SAHRIWAL, YARVUL

INITIAL EXAMINATION REPORT

Surname ERIMPADAKANDI	
Forenames SUBRAMMANNIAN	
Address TRUCKOMAN	
Place of examination RS PAC CLINIC BHAJA	Date 26 / 06 / 19 DOB: 06/05/1964, CIVIL-77194868, STAFF-6623
Home Telephone number 97288407	

If a dependant or fancee entr employees name jere :-

Surname :

Forenames:

Nationality INDIAN		Country of birth INDIA		Religion HINDUISM	
<input checked="" type="checkbox"/> Male	<input checked="" type="checkbox"/> Single	<input checked="" type="checkbox"/> Widow(er)	Relationship to employee		Number of Children
<input checked="" type="checkbox"/> Female	<input checked="" type="checkbox"/> Married	<input checked="" type="checkbox"/> Divorced Separated	<input checked="" type="checkbox"/> Wife	<input type="checkbox"/> Son	<input type="checkbox"/> Daughter
Reason for examination <input checked="" type="checkbox"/> Pre-employment		Job :- DRIVER (HEAVY)		<input type="checkbox"/> Fiancee	
<input type="checkbox"/> Pre-overseas		Area:- BHAJA		1	
Name and address of family doctor			List your last 3 jobs		
			(1)		
			(2)		
			(3)		

Are you Registered Disabled Person? (UK

☐

Do you belong to any Medical Insurance Scheme?

☐

DO YOU HAVE OR HAVE YOU HAD :- (Tick 'yes' or 'No' column or put a (?) If uncertain exclude minor ailments.)

	Y	N		Y	N		Y	N
1. Sirius rouble		<input checked="" type="checkbox"/>	22. Heart Disease		<input checked="" type="checkbox"/>	42. Awarded benifities for Industrial injury/illness		<input checked="" type="checkbox"/>
2. Neck swellings/flands		<input checked="" type="checkbox"/>	23. Rheumatic Fever		<input checked="" type="checkbox"/>	43. Treated for a mental condition. eg . depression		<input checked="" type="checkbox"/>
3. Difficulty in vision		<input checked="" type="checkbox"/>	24. Abnormal heartbeat		<input checked="" type="checkbox"/>	44. Treated for problem drinking or drug abuse		<input checked="" type="checkbox"/>
4. Any ear discharge		<input checked="" type="checkbox"/>	25. High blood pressure		<input checked="" type="checkbox"/>	45. Exposed to toxic substance or noise		<input checked="" type="checkbox"/>
5. Asthma/bronchitis		<input checked="" type="checkbox"/>	26. Stroke		<input checked="" type="checkbox"/>	FOR WOMEN ONLY		
6. Hayfever/other allergy		<input checked="" type="checkbox"/>	27. Serious chest pain		<input checked="" type="checkbox"/>	Have you aver had:-		
7. Any skin trouble		<input checked="" type="checkbox"/>	28. Any blood disease		<input checked="" type="checkbox"/>	46. An abnormal smear		
8. Tuberculosis		<input checked="" type="checkbox"/>	29. Kidney disease		<input checked="" type="checkbox"/>	47. Any gynaecological treatment		
9. Shortness of breath		<input checked="" type="checkbox"/>	30. Painful passage of urine		<input checked="" type="checkbox"/>	48. Are you pregnant?		
10. Coughed/vomited blood		<input checked="" type="checkbox"/>	31. Blood in urine		<input checked="" type="checkbox"/>	49. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE ?		
11. Severe abdominal pain		<input checked="" type="checkbox"/>	32. Diabetes		<input checked="" type="checkbox"/>			
12. Stomach ulcer		<input checked="" type="checkbox"/>	33. Headaches /migraine		<input checked="" type="checkbox"/>			
13. Recurrent indigestion		<input checked="" type="checkbox"/>	34. Dizziness/tainting		<input checked="" type="checkbox"/>			
14. Jaundice or hepatitis		<input checked="" type="checkbox"/>	35. Epilepsy		<input checked="" type="checkbox"/>			
15. Gall bladder disease		<input checked="" type="checkbox"/>	36. Joints/spinal trouble		<input checked="" type="checkbox"/>			
16. Marked change in bowel habits		<input checked="" type="checkbox"/>	37. Surgical operation		<input checked="" type="checkbox"/>			
17. Blood in stools (motions)		<input checked="" type="checkbox"/>	38. Serious accident /tracture		<input checked="" type="checkbox"/>			
18. Marked change in weight		<input checked="" type="checkbox"/>	39. Tropical disease		<input checked="" type="checkbox"/>			
19. Varicose veins		<input checked="" type="checkbox"/>	40. Fear of heights		<input checked="" type="checkbox"/>			
20. Lump in breast/armpit		<input checked="" type="checkbox"/>	HAVE YOU EVER BEEN:-		<input checked="" type="checkbox"/>			
21. Cancer		<input checked="" type="checkbox"/>	41. Rejected for employment or insurance for medical reasons		<input checked="" type="checkbox"/>			

How much tabacco each day ?

Non-smoker

Average daily alcohol consumption

No

Family history	Diabetes <input checked="" type="checkbox"/>	Tuberculosis <input checked="" type="checkbox"/>	Epilepsy <input checked="" type="checkbox"/>	Asthama <input checked="" type="checkbox"/>	Eczerna <input checked="" type="checkbox"/>
	Heart disease <input checked="" type="checkbox"/>	High blood pressure <input checked="" type="checkbox"/>	Stroke <input checked="" type="checkbox"/>	Cancer <input checked="" type="checkbox"/>	Blood disease <input checked="" type="checkbox"/>

PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT :-


I declare these statements to be true to the best of my knowledge and belief and I agree that the result of this medical 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

26 06 19

Signature of applicant

FOR COMPLETION BY EXAMINING DOCTOR OR SISTER
FURTHER DETAILS OF MEDICAL HISTORY AND RECREATIONAL ACTIVITIES

N - Normal A - Abnormal Please Describe		PHYSICAL EXAMINATION
✓	1. Eyes & Pupils	<p>BME-23.4ug/m²</p> <p>HR-80b/min</p> 
✓	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. Muscula-skeletal	
✓	12. Skin & Varicose Vns.	
✓	13. C.N.S.	
✓	14. Breasts	
	15.	

HEIGHT cm	WEIGHT kg	B.P.	HEARING L	HEARING R	VISION: Uncorrected	DISTANT R L	NEAR R L	COLOUR VISION	BLOOD GROUP
161	60.6	164/100							

N	A	LABORATORY AND SPECIAL INVESTIGATIONS	N	A
✓	1. Urinalysis	<p>TC-267mg/dl</p> <p>HDL-35.24mg/dl</p> <p>LDL-142.37mg/dl</p>		6. Audiogram
✓	2. Hb Bloodcount ESR			7. Lung Function
	3. Serum Profile			8. Chest X-Ray
	4. Stool			9. Drug Screen
	5. E.C.G.			10. CR Screen

OTHER FINDINGS (physique, scars, disabilities, mental stability etc.)

BME-23.4ug/m²

Advt

- Regular exercise
- Avoid high fat diet
- Repeat RLP after 3 months.

ASSESSMENT

* He was found to have 10 years ~~at~~ risk of 28.5%.
Therefore, he was referred to cardiologist on 29.06.19
Consequently, TMT was done and found negative
for rheumatism. Hence, he is mentioned fit by the
cardiologist.

☒ FIT ALL AREAS ☐ FIT HOME SERVICES ONLY ☐ UNFIT/UNSUITABLE ☐ MAY BE REASSESSED

Date 10.07.19 Signature

DR. HASAN MAHBUB KHAN BAYZID
MEDICAL OFFICER
RUSAYL HEALTH CENTRE
MOH LIC NO. 13691

Doctor / Sister

REVIEW/CONSULTATION

Date Signature Name (Block Capitals) Doctor / Sister