

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE

ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Surname/Forenames		SubRAMANIAN THIRUPADA KANDI	
Nationality		INDIAN	

Mobile No.	97088401	Home/Leave Address:	Company Number:	Reference Indicator:
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Personal Details		58 years	ENIL ID - 77194868
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A <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married	<input type="checkbox"/> Single	<input type="checkbox"/> Separated /Divorced /Widow(er)
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Home/Leave Address:	<input type="checkbox"/> Wife	<input type="checkbox"/> Son	<input type="checkbox"/> Daughter	No of Children: 2
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Reason for Examination (tick as appropriate)				
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Periodic Medical Examination <input type="checkbox"/>	Final / Retirement <input type="checkbox"/>	Other Reason: <input type="checkbox"/>
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Employee only				
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B Present Job and Location: HSD, TRELLOMAN	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?		<input checked="" type="checkbox"/>
Do you smoke? If yes, what and how much each day?		<input checked="" type="checkbox"/>
Do you drink alcohol? If yes, what is your average weekly intake?		<input checked="" type="checkbox"/>
Have you ever taken elicited/recreational drugs?		<input checked="" type="checkbox"/>
Are you doing regular sports or physical activities?		<input checked="" 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: 07/2022	Signature of Applicant:
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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 /mins.	HEARING L (N) R (N)	Uncorrected Corrected	DISTANT 96 86	VISION NEAR R L
160	66	23	158/100	101/90 88				

N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A
		1. Urinalysis		
		2. Hb, Bloodcount, ESR		
		3. LFT, RFT, RBS		
		4. Drug Screen		
		5. Lipids (40 years +)		
		6. Sickle Cell test		

Total chol - 270 mg/dl
HDL - 45 mg/dl
LDL - 203 mg/dl
Total Bili - 1.3 mg/dl
FRS - 26.7%
ECG - RBBB, T wave inversion VI, VII, VIII

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

Mild hypertension
Diastolic hypertension
Dyslipidemia
High bilirubin
Abnormal ECG

ASSESSMENT AND RECOMMENDATIONS:

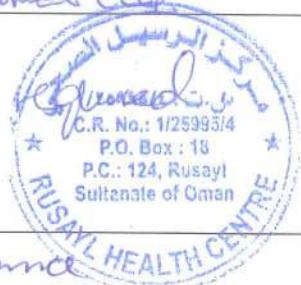
FIT ALL AREAS

FIT WITH RESTRICTION

TEMPORARY UNFIT

UNFIT

Cardiology review from General medicine fitness



Date:

Name (Block Capitals): Dr. / Nurse

Signature: -

REVIEW/CONSULTATION

Sept 3, 2022 w/ MRI + Cardio Clearance
P/ fit to Work; Start lisinopril 10 mg OD, Torvast 10 mg OD;
Weekly BP monitoring, repeat liver profile in Dec 2022

Date:

Name (Block Capitals): Dr. / Nurse

Signature: -

DR. ROMMEL WHIGAN MELLENDRES

GENERAL PRACTITIONER

RUSAYL HEALTH CENTRE

MOH LIC NO. 13952

Dr. Chinmaya