



مركز الرسيل الصحي  
RUSAYL HEALTH CENTRE

ISO 9001-2015 Certified Co.

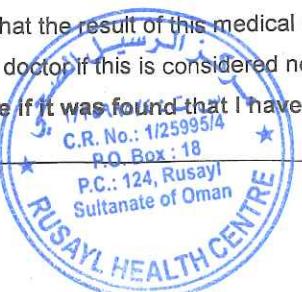
INITIAL EXAMINATION REPORT (MEDICAL - CONFIDENTIAL) No. A 4348



RUSAYL HEALTH CENTRE

ISO 9001-2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Place of examination <b>Nimr</b>		Date <b>11/07/22</b>	Surname <b>KUMAR</b>			
If a dependant enter employee's name here:		Forenames <b>NARESH</b>				
Surname:		Address				
Birth date: <b>26/03/1982</b>		Nationality: <b>INDIAN</b>	Country of birth: <b>INDIA</b>	Religion: <b>HINDU</b>		
<input checked="" type="checkbox"/> Male	<input type="checkbox"/> Female	<input checked="" type="checkbox"/> Married	<input type="checkbox"/> Single	<input type="checkbox"/> Separated /Divorced		
Reason for examination		Pre-Employment	<input checked="" type="checkbox"/> Job: <b>Electrician</b>	Relationship to employee		
		Pre-Overseas	<input type="checkbox"/> Area: <b>Nimr</b>	<input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter		
Name and address of family doctor		List your last 3 jobs				
		(1)				
		(2)				
Are you a Registered Disabled Person? (UK only)		<input type="checkbox"/>	Do you belong to any Medical Insurance Scheme? <input type="checkbox"/>			
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. Sinus trouble		<input checked="" type="checkbox"/> 21. Cancer		<input checked="" type="checkbox"/> HAVE YOU EVER BEEN:-		
2. Neck swelling/glands		<input checked="" type="checkbox"/> 22. Heart Disease		<input checked="" type="checkbox"/> 40. Rejected for employment or insurance for medical reasons		
3. Difficulty in vision		<input checked="" type="checkbox"/> 23. Rheumatic fever		<input checked="" type="checkbox"/> 41. Awarded benefits for industrial injury/illness		
4. Any ear discharge		<input checked="" type="checkbox"/> 24. Abnormal heartbeat		<input checked="" type="checkbox"/> 42. Treated for a mental condition, e.g. depression		
5. Asthma/bronchitis		<input checked="" type="checkbox"/> 25. High blood pressure		<input checked="" type="checkbox"/> 43. Treated for problem drinking or drug abuse		
6. Hayfever /other significant allergy		<input checked="" type="checkbox"/> 26. Stroke		<input checked="" type="checkbox"/> 44. Exposed to toxic substance or noise		
7. Any skin trouble		<input checked="" type="checkbox"/> 27. Serious chest pain		<input checked="" type="checkbox"/> FOR WOMEN ONLY		
8. Tuberculosis		<input checked="" type="checkbox"/> 28. Any blood disease		<input checked="" type="checkbox"/> Have you ever had:-		
9. Shortness of breath		<input checked="" type="checkbox"/> 29. Kidney disease		<input checked="" type="checkbox"/> 45. An abnormal smear		
10. Coughed/vomited blood		<input checked="" type="checkbox"/> 30. Blood in urine		<input checked="" type="checkbox"/> 46. Any gynaecological treatment		
11. Severe abdominal pain		<input checked="" type="checkbox"/> 31. Diabetes		<input checked="" type="checkbox"/> 47. Are you pregnant?		
12. Stomach ulcer		<input checked="" type="checkbox"/> 32. Headaches/migraine		<input checked="" type="checkbox"/> 48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE		
13. Recurrent indigestion		<input checked="" type="checkbox"/> 33. Dizziness/fainting				
14. Jaundice or hepatitis		<input checked="" type="checkbox"/> 34. Epilepsy				
15. Gall Bladder disease		<input checked="" type="checkbox"/> 35. Joints/spinal trouble				
16. Marked change in bowel habits		<input checked="" type="checkbox"/> 36. Surgical operation				
17. Blood in stools (motions)		<input checked="" type="checkbox"/> 37. Serious accident/fracture				
18. Marked change in weight		<input checked="" type="checkbox"/> 38. Tropical disease				
19. Varicose veins		<input checked="" type="checkbox"/> 39. Fear of heights				
20. Lump in breast/armpit		<input checked="" type="checkbox"/>				
How much tobacco each day?		Average daily alcohol consumption				
Have you ever taken elicited drugs? ( <input checked="" type="checkbox"/> ) PDO test all new/potential employees for elicited/recreational drugs						
FAMILY HISTORY:		Diabetes ( <input checked="" type="checkbox"/> )	Tuberculosis ( <input checked="" type="checkbox"/> )	Epilepsy ( <input checked="" type="checkbox"/> )	Asthma ( <input checked="" type="checkbox"/> )	Eczema ( <input checked="" type="checkbox"/> )
		Heart disease ( <input checked="" type="checkbox"/> )	High blood pressure ( <input checked="" type="checkbox"/> )	Stroke ( <input checked="" type="checkbox"/> )	Blood Disease ( <input checked="" type="checkbox"/> )	Cancer ( <input checked="" type="checkbox"/> )
PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT:-						
I declared these statements to be true to the best of my knowledge and belief and I agree that the result of this medical examination 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. I am also aware that PDO reserve the right to dismiss me if it was found that I have purposely withheld important medical information.						
 <p>C.R. No.: 1/25995/4 P.O. Box: 18 P.C.: 124, Rusayl Sultanate of Oman</p>						

Date: **11/07/2022**

Signature of Applicant: **NARESH**

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 R	VISION DISTANT Uncorrected Corrected	NEAR R L R L	Colour Vision	Blood Group
172	65	22.0	104/70	72	N H	6/6 6/6	6/6 6/6	W	

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 NA			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.)

Increased physical exercise and better dietary fat intake advised. Report lipid profile in 6 months.

ASSESSMENT:

FIT ALL AREAS

FIT WITH RESTRICTION

TEMPORARY UNFIT

UNFIT

Date: 11/07/22

Name (Block Capitals): Dr. / Nurse

DR. INNOCENT IFEANYI NWOKEDI UKO  
GENERAL PRACTITIONER  
RUSAYL HEALTH CENTRE  
MOH LIC NO. 20062

Signature: *fh*

REVIEW/CONSULTATION

Date:

Name (Block Capitals): Dr. / Nurse

Signature:

