



مركز الرسيل الصحي RUSAYL HEALTH CENTRE

ISO 9001 - 2015 Certified Co.

INITIAL EXAMINATION REPORT (MEDICAL - CONFIDENTIAL) No. A

4348



RUSAYL HEALTH CENTRE

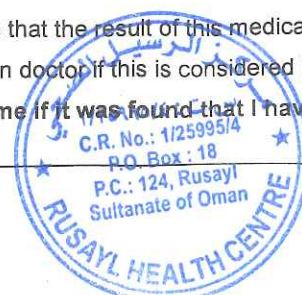
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PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Place of examination <u>Nunur</u>		Date <u>11/07/22</u>	Surname <u>KUMAR</u>	
If a dependant enter employee's name here: Surname:		Forenames <u>NARESH</u>		
Birth date: <u>25/03/1984</u>		Nationality: <u>INDIAN</u>	Address	
Country of birth: <u>INDIA</u>		Home telephone number <u>72070376</u>		Forenames: <u>Civil id - 120205663</u>
Religion: <u>SIKH</u>		Relationship to employee		Number of children: <u>2</u>
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced	<input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter		
Reason for examination		Pre-Employment <input checked="" type="checkbox"/> Job: <u>Electrician</u>		
Pre-Overseas <input type="checkbox"/>		Area: <u>Nunur</u> AGE - <u>38yrs</u>		
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
1. Sinus trouble		<input checked="" type="checkbox"/>	21. Cancer	<input checked="" type="checkbox"/>
2. Neck swelling/glands		<input checked="" type="checkbox"/>	22. Heart Disease	<input checked="" type="checkbox"/>
3. Difficulty in vision		<input checked="" type="checkbox"/>	23. Rheumatic fever	<input checked="" type="checkbox"/>
4. Any ear discharge		<input checked="" type="checkbox"/>	24. Abnormal heartbeat	<input checked="" type="checkbox"/>
5. Asthma/bronchitis		<input checked="" type="checkbox"/>	25. High blood pressure	<input checked="" type="checkbox"/>
6. Hayfever /other significant allergy		<input checked="" type="checkbox"/>	26. Stroke	<input checked="" type="checkbox"/>
7. Any skin trouble		<input checked="" type="checkbox"/>	27. Serious chest pain	<input checked="" type="checkbox"/>
8. Tuberculosis		<input checked="" type="checkbox"/>	28. Any blood disease	<input checked="" type="checkbox"/>
9. Shortness of breath		<input checked="" type="checkbox"/>	29. Kidney disease	<input checked="" type="checkbox"/>
10. Coughed/vomited blood		<input checked="" type="checkbox"/>	30. Blood in urine	<input checked="" type="checkbox"/>
11. Severe abdominal pain		<input checked="" type="checkbox"/>	31. Diabetes	<input checked="" type="checkbox"/>
12. Stomach ulcer		<input checked="" type="checkbox"/>	32. Headaches/migraine	<input checked="" type="checkbox"/>
13. Recurrent indigestion		<input checked="" type="checkbox"/>	33. Dizziness/fainting	<input checked="" type="checkbox"/>
14. Jaundice or hepatitis		<input checked="" type="checkbox"/>	34. Epilepsy	<input checked="" type="checkbox"/>
15. Gall Bladder disease		<input checked="" type="checkbox"/>	35. Joints/spinal trouble	<input checked="" type="checkbox"/>
16. Marked change in bowel habits		<input checked="" type="checkbox"/>	36. Surgical operation	<input checked="" type="checkbox"/>
17. Blood in stools (motions)		<input checked="" type="checkbox"/>	37. Serious accident/fracture	<input checked="" type="checkbox"/>
18. Marked change in weight		<input checked="" type="checkbox"/>	38. Tropical disease	<input checked="" type="checkbox"/>
19. Varicose veins		<input checked="" type="checkbox"/>	39. Fear of heights	<input checked="" type="checkbox"/>
20. Lump in breast/armpit		<input checked="" type="checkbox"/>		
How much tobacco each day?		Average daily alcohol consumption		
Have you ever taken elicited drugs? (A) PDO test all new/potential employees for elicited/recreational drugs				
FAMILY HISTORY: Diabetes (A) Tuberculosis (X) Epilepsy (X) Asthma (X) Eczema (X)				
Heart disease (A) High blood pressure (X) Stroke (X) Blood Disease (X) Cancer (X)				

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.



Date: 11/07/2022

Signature of Applicant: [Signature]



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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	NA
✓		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 NEAR Uncorrected Corrected	Colour Vision	Blood Group
172	65	22.0	104 70	72	N N	R L R L 6/6 6/6 6/6 6/6	(N)	

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 reduce dietary fat
intake advised. Repeat lipid profile in 6 months.

ASSESSMENT:

☒ FIT ALL AREAS ☐ FIT WITH RESTRICTION ☐ TEMPORARY UNFIT ☐ UNFIT

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

Date: 11/07/22 Name (Block Capitals): Dr. / Nurse

Signature:

REVIEW/CONSULTATION

Date: Name (Block Capitals): Dr. / Nurse

Signature:

