

1283

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS



ریاضیہ سیلو
RUSAYL HEALTH CENTRE
NMR, FAHUD, GARNALAM, BHAJA, SAIRIWAL, MARMUL

INITIAL EXAMINATION REPORT

Surname praveen Ramanan padmanabhan

Forenames 008-27-05-81, en-74371277

Address Truelkoman, Bahja,aima

Place of examination Date / /
bahja 9-1-19

Home Telephone number 92497525

If a dependant or fiancee entr employees name jere :-

Surname :

Forenames:

Naticality Indian

Country of birth India

Religion Hindu

<input checked="" type="checkbox"/> Male	<input type="checkbox"/> Single	<input type="checkbox"/> Widow(er)	<input type="checkbox"/> Wife	<input type="checkbox"/> Son	<input checked="" type="checkbox"/> Daughter	<input type="checkbox"/> Fiancee	Number of Children
<input type="checkbox"/> Female	<input checked="" type="checkbox"/> Married	<input type="checkbox"/> Divorced Separated					2

Reason for examination Pre-employment

Job :- Supervisor

Poo Medical Pre-overseas

Area:-aima

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 ailmenis.)

	Y	N
1. Sirius rouble		✓
2. Neck swellings/flands		✓
3. Difficulty in vision		✓
4. Any ear discharge		✓
5. Asthma/bronchitis		✓
6. Hayfever/other allergy		✓
7. Any skin trouble		✓
8. Tuberculosis		✓
9. Shortness of breath		✓
10. Coughed/vomited blood		✓
11. Severe abdominal pain		✓
12. Stomach ulcer		✓
13. Recurrent indigestion		✓
14. Jaundice or hepatitis		✓
15. Gall bladder disease		✓
16. Marked change in bowel habits		✓
17. Blood in stools (motions)		✓
18. Marked change in weight		✓
19. Varicose veins		✓
20. Lump in breast/armpit		✓
21. Cancer		✓

	Y	N
22. Heart Disease		✓
23. Rheumatic Fever		✓
24. Abnormal heartbeat		✓
25. High blood pressure		✓
26. Stroke		✓
27. Serious chest pain		✓
28. Any blood disease		✓
29. Kidney disease		✓
30. Painful passage of urine		✓
31. Blood in urine		✓
32. Diabetes		✓
33. Headaches /migraine		✓
34. Dizziness/tainting		✓
35. Epilepsy		✓
36. Joints/spinal trouble		✓
37. Surgical operation		✓
38. Serious accident /fracture		✓
39. Tropical disease		✓
40. Fear of heights		✓
HAVE YOU EVER BEEN:-		
41. Rejected for employment or insurance for medical reasons		✓

	Y	N
42. Awarded benifities for Industrial injury/lilness		✓
43. Treated for a mental condition. eg . depression		✓
44. Treated for problem drinking or drug abuse		✓
45. Exposed to toxic substance or noise		✓
FOR WOMEN ONLY		
Have you ever had:-		
46. An abnormal smear		
47. Any gynaecological treatment		
48. Are you pregnant?		
49. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE ?		

How much tabacco each day ?

NA

Average daily alcohol consuption

NA

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

9-1-19

Signature of applicant

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

Normal A - Abnormal Please Describe		PHYSICAL EXAMINATION																																								
<table border="1"> <thead> <tr> <th>A</th> <th></th> </tr> </thead> <tbody> <tr><td>1. Eyes & Pupils</td><td></td></tr> <tr><td>2. E.N.T.</td><td></td></tr> <tr><td>3. Teeth & Mouth</td><td></td></tr> <tr><td>4. Lungs & Chest</td><td></td></tr> <tr><td>5. Cardiovascular System</td><td></td></tr> <tr><td>6. Abdo. Viscera</td><td></td></tr> <tr><td>7. Hernial Orifices</td><td></td></tr> <tr><td>8. Anus & Rectum</td><td></td></tr> <tr><td>9. Genito - urinary</td><td></td></tr> <tr><td>10. Extremities</td><td></td></tr> <tr><td>11. Muscula-skeletal</td><td></td></tr> <tr><td>12. Skin & Varicose Vns.</td><td></td></tr> <tr><td>13. C.N.S.</td><td></td></tr> <tr><td>14. Breasts</td><td></td></tr> <tr><td>15.</td><td></td></tr> </tbody> </table>		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. Muscula-skeletal		12. Skin & Varicose Vns.		13. C.N.S.		14. Breasts		15.		<p>• Bmi : 32.5 kg/cm²</p>								
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HEIGHT cm 178	WEIGHT kg 60.3	B.P. 124/78 mmHg	HEARING L R	HEARING L R	VISION: Uncorrected Corrected	DISTANT R L	NEAR R L	COLOUR VISION	BLOOD GROUP																																	
LABORATORY AND SPECIAL INVESTIGATIONS					N	A	<p>• Dyslipidemia</p>																																			
1. Urimalysis							6. Audiogram																																			
2. Hb Bloodcount ESR							7. Lung Function																																			
3. Sarum 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.)

• BM: obese

→ Advise :

- Do regular physical exercise.
- Avoid extra calories and fatty foods.
- Take medications from clinic regularly.

ASSESSMENT

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

Date 13-01-19

Signature

DR. MOHAMMAD MARUF FERDOUS
Name (Block Capitals) CER
RUSAYL HEALTH CENTRE
MOH LIC NO. 12930

Doctor / Sister

REVIEW/CONSULTATION

Date

Signature

Name (Block Capitals)

Doctor / Sister

