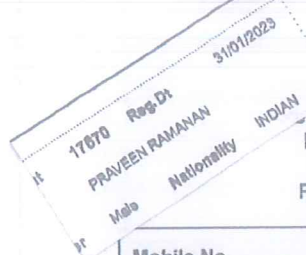


(283)

TRUCK OMAN

Appendix 33: EX2 Form (Routine/Periodic Medical Examination)

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL –
CONFIDENTIAL)Ministry of Health
Sultanate of Oman
MEDICAL DEPARTMENTPLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALSSurname/
Forenames

PRAVEEN RAMANAN

Nationality

INDIA DOB 27/05/1981

Mobile No.

92497525

Address:

74371277

Company Number:

Reference Indicator:

Personal Details

A ☒ Male ☐ Female☒ Married ☐ Single ☐ Separated /Divorced /Widow(er)

Home/Leave Address:

Relationship to employee

☐ Wife ☐ Son ☐ Daughter

No of Children: 2

Reason for Examination (tick as appropriate)

Periodic Medical Examination ☒Final / Retirement ☐Other Reason: ☐

Employee only

B Present Job and Location:

SUPERVISOR - HAIMA

Next Job and Location:

Are you a registered person with special needs? ☐Do you belong to any Medical Insurance Scheme? ☐**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?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
1 Ear, nose, eye or throat problems	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
2 Chest problems like asthma, bronchitis, another bad cough	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
3 Heart abnormality, chest pains	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
4 Abdominal pains, abnormal bowel motions	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
5 Urogenital problems (kidney disease, menstrual disorder)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
6 Skin trouble or allergies	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
7 Epileptic fits, dizzy spells or migraine	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
8 History of mental illness, depression anxiety	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
9 Diabetes, thyroid disease, history of Hypertension	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
10 Blood disorder e.g. anaemia, blood cancer e.g. leukaemia	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
11 Any history of accidents or fractures	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
12 Have you had any serious allergies	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
13 Do any dependants have a significant ongoing illness?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
14 Any family history of cancers	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Do you take any regular medicines, or have your taken in the past?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Do you smoke? If yes, what and how much each day?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Do you drink alcohol? If yes, what is your average weekly intake?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Have you ever taken elicited/recreational drugs?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Are you doing regular sports or physical activities?	<input checked="" type="checkbox"/>	<input 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: 31/01/2023

Signature of Applicant:





Appendix 33: EX2 Form (Routine/Periodic Medical Examination)

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL –
CONFIDENTIAL)

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	HEARING	VISION	
183		112	33.4	115 80 mmhg	68/mins.	L N R N	DISTANT NEAR R L R L Uncorrected Corrected 6/6 6/6	
Color Vision		1. Normal 2. Abnormal						
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS				N	A	
/		1. Urinalysis					/	
/		2. Hb, Blood count, ESR					/	
/		3. LFT, RFT, RBS					/	
/		4. Drug Screen					/	
/		5. Lipids (40 years +)					/	
/		6. Sickle Cell test					/	
		7. Audiogram					/	
		8. Lung Function					/	
		9. Chest X-Ray					/	
		10. ECG					/	
		11. CVS risk for 40 yrs. & above					/	
		12. HIV, Hepatitis screening					/	
OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)								
high BMI → Life style modification								
ASSESSMENT AND RECOMMENDATIONS:								
<input checked="" type="checkbox"/> FIT ALL AREAS <input type="checkbox"/> FIT WITH RESTRICTION <input type="checkbox"/> TEMPORARY UNFIT <input type="checkbox"/> UNFIT								
Date:		Name (Block Capitals): Dr. / Nurse				Signature:		
Date:		Name (Block Capitals): Dr. / Nurse				Signature:		
REVIEW/CONSULTATION		DR. FARZAD FARHAD ABBASMANESH GENERAL PRACTITIONER M.O.H LICENSE NO. 20379						