

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS



ریسال ہیلث سینٹر
RUSAYL HEALTH CENTRE
NIMR, FAHUD, QARVALAV, BHAJA, SAHRIWAL, MARWAL

INITIAL EXAMINATION REPORT

Place of examination NIMR	Date 22/08/22	Home Telephone number 71310521
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If a dependant or fiancee entr employees name jere :-

Surname: Forenames: Age: 38 yrs.

DOB: 28/04/1984		Nationality INDIAN	Country of birth INDIA	Religion HINDU
<input checked="" type="checkbox"/> Male	<input type="checkbox"/> Single	Widow(er)	Relationship to employee	
<input type="checkbox"/> Female	<input checked="" type="checkbox"/> Married	Divorced Separated	<input type="checkbox"/> Wife	<input type="checkbox"/> Son
			<input type="checkbox"/> Daughter	<input type="checkbox"/> Fiancee
			Number of Children 1	

Reason for examination Pre-employment Job: MECHANIC
 Pre-overseas Area: NIMR

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 (?) It uncerlain exclude minor ailmenis.)

	Y	N		Y	N		Y	N
1. Sirius rouble		✓	22. Heart Disease		✓	42. Awarded benifities for Industrial injury/lilness		✓
2. Neck swellings/flands		✓	23. Rheumatic Fever		✓	43. Treated for a mental condition, eg . depression		✓
3. Difficulty in vision		✓	24. Abnormal heartbeat		✓	44. Treated for problem drinking or drug abuse		✓
4. Any ear discharge		✓	25. High blood pressure		✓	45. Exposed to toxic substance or noise		✓
5. Asthma/bronchitis		✓	26. Stroke		✓	FOR WOMEN ONLY		
6. Hayfever/other allergy		✓	27. Serious chest pain		✓	Have you ever had:-		
7. Any skin trouble		✓	28. Any blood disease		✓	46. An abnormal smear		
8. Tuberculosis		✓	29. Kidney disease		✓	47. Any gynaecological treatment		
9. Shortness of breath		✓	30. Painful passage of urine		✓	48. Are you pregnant?		
10. Coughed/vomited blood		✓	31. Blood in urine		✓	49. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE ?		
11. Severe abdominal pain		✓	32. Diabetes		✓			
12. Stomach ulcer		✓	33. Headaches /migraine		✓			
13. Recurrent indigestion		✓	34. Dizziness/tainting		✓			
14. Jaundice or hepatitis		✓	35. Epilepsy		✓			
15. Gall bladder disease		✓	36. Joints/spinal trouble		✓			
16. Marked change in bowel habits		✓	37. Surgical operation		✓			
17. Blood in stools (motions)		✓	38. Serious accident /fracture		✓			
18. Marked change in weight		✓	39. Tropical disease		✓			
19. Varicose veins		✓	40. Fear of heights		✓			
20. Lump in breast/armpit		✓	HAVE YOU EVER BEEN:-					
21. Cancer		✓	41. Rejected for employment or insurance for medical reasons		✓			

How much tabacco each day?

Average daily alcohol consuption

Family history	Diabetes <input checked="" type="checkbox"/>	Tuberculosis <input checked="" type="checkbox"/>	Epilepsy <input checked="" type="checkbox"/>	Asthama <input checked="" type="checkbox"/>	Eczerna <input checked="" type="checkbox"/>	Cancer <input checked="" type="checkbox"/>	Blood disease <input checked="" type="checkbox"/>
	Heart disease <input checked="" type="checkbox"/>	High blood pressure <input checked="" type="checkbox"/>		Stroke <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 22/08/22

Signature of applicant

Narinder Singh



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

N - Normal A - Abnormal Please Describe			PHYSICAL EXAMINATION								
N	A		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. Muscula-skeletal 12. Skin & Varicose Vns. 13. C.N.S. 14. Breasts 15.											
HEIGHT cm	WEIGHT kg	B.P.	HEARING L <u>N</u> R <u>N</u>	HEARING L <u>N</u> R <u>N</u>	VISION: Uncorrected	DISTANT R <u>6/6</u> L <u>6/6</u>	NEAR R <u>6/6</u> L <u>6/6</u>	COLOUR VISION <u>(N)</u>	BLOOD GROUP		
164	62	130/80 P.R. 84			Corrected						
N	A		LABORATORY AND SPECIAL INVESTIGATIONS					N	A		
<input checked="" type="checkbox"/>		1. Urimalysis						<input checked="" type="checkbox"/>		6. Audiogram	
<input checked="" type="checkbox"/>		2. Hb Bloodcount ESR								7. Lung Function	
<input checked="" type="checkbox"/>		3. Serum Profile								8. Chest X-Ray	
<input checked="" type="checkbox"/>		4. Stool <u>N/A</u>								9. Drug Screen	
<input checked="" type="checkbox"/>		5. E.C.G. <u>N/A</u>								10. CR Screen	
OTHER FINDINGS (physique, scars, disabilities, mental stability etc.)											

Mildly elevated lipid (Total cholesterol - 224 & LDL-152)
Low fat diet, Regular exercise advised. Repeat Lipid profile after 6 months.

ASSESSMENT

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

Date

22/08/22

Signature

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

Name (Block Capitals)



REVIEW/CONSULTATION

Date

Signature

Name (Block Capitals)

Doctor / Sister