

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)

RUSAYL HEALTH CENTRE

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Surname/ Forenames:	KHALID MOHAMMED SALIM AL SHIBANI 39YRS/M		
Nationality:	OMANI		

Mobile No. 92265564	Home/Leave Address: ADAM	Company Number: 10001	Reference Indicator: TRUCK OMAN
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Personal Details

A <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced
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Home/Leave Address: ADAM	Relationship To Employee <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	No Of Children:
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Reason For Examination (tick As Appropriate)

Periodic Medical Examination <input type="checkbox"/> Initial <input checked="" type="checkbox"/> Periodic
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Employee Only

B Present Job And Location: NIMR-SUPERVISOR	Next Job And Location: NIMR
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Are You A Registered Person With Special Needs? <input type="checkbox"/>	Do You Belong To Any Medical Insurance Scheme? <input type="checkbox"/>
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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 type="checkbox"/>	<input type="checkbox"/>	
Ear, Nose, Eye Or Throat Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Chest Problems Like Asthma, Bronchitis, Other Bad Cough	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Abnormality, Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	
Abdominal Pains, Abnormal Bowel Motions	<input type="checkbox"/>	<input type="checkbox"/>	
Urogenital Problems (kidney Disease, Menstrual Disorder)	<input type="checkbox"/>	<input type="checkbox"/>	
Skin Trouble Or Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
Epileptic Fits, Dizzy Spells Or Migraine	<input type="checkbox"/>	<input type="checkbox"/>	
History Of Mental Illness, Depression Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes, Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Blood Disorder E.G. Anaemia, Blood Cancer E.G. Leukaemia	<input type="checkbox"/>	<input type="checkbox"/>	
Any History Of Accidents Or Fractures	<input type="checkbox"/>	<input type="checkbox"/>	
Have You Had Any Serious Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
Any Family History Of Cancers	<input type="checkbox"/>	<input type="checkbox"/>	
Do You Take Any Regular Medicines, Or Have You Taken In The Past	<input type="checkbox"/>	<input type="checkbox"/>	
Do You Smoke? If Yes, What And How Much Each Day?	<input type="checkbox"/>	<input type="checkbox"/>	
Do You Drink Alcohol? If Yes, What Is Your Average Weekly Intake?	<input type="checkbox"/>	<input type="checkbox"/>	
Have You Ever Taken Elicited/recreational Drugs?	<input type="checkbox"/>	<input type="checkbox"/>	
Are You Doing Regular Sports Or Physical Activities?	<input type="checkbox"/>	<input checked="" 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. | 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: 12/11/2023

Signature :



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								
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Eyes Pupils							
<input checked="" type="checkbox"/>	<input type="checkbox"/>	ENT							
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Teeth Mouth							
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Lungs Chest							
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Cardiovascular System							
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Abdo Viscera							
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Hernal Orifices							
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Anus Rectum							
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Genito Urinary							
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Extremities							
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Musculo Skeletal							
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Skin Varicose Vns							
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Cns							
HEIGHT 162 Cm	WEIGHT 115 Kg	BMI 43	B.P 126/82	PULSE 78/mins	HEARING L: NORMAL R: NORMAL	VISION: RIGHT 6/6 , LEFT 6/6		Colour Vision: N	Blood Group: N/A
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS					N	A	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	1.Urinalysis					<input type="checkbox"/>	<input type="checkbox"/>	7.Audiogram
<input checked="" type="checkbox"/>	<input type="checkbox"/>	2 Hb, Bloodcount, ESR					<input type="checkbox"/>	<input type="checkbox"/>	8. Lung Function
<input checked="" type="checkbox"/>	<input type="checkbox"/>	3 LFT, RFT, RBS/FBS					<input type="checkbox"/>	<input type="checkbox"/>	9. Chest X-Ray
<input type="checkbox"/>	<input type="checkbox"/>	4. Drug Screen					<input type="checkbox"/>	<input type="checkbox"/>	10. ECG
<input checked="" type="checkbox"/>	<input type="checkbox"/>	5. Lipids (40 Years +)					<input type="checkbox"/>	<input type="checkbox"/>	11. CVD Risk For 40 Yrs. & Above
<input type="checkbox"/>	<input type="checkbox"/>	6. Sickle Cell Test					<input type="checkbox"/>	<input type="checkbox"/>	12. HIV, Hepatitis Screening

OTHER FINDINGS (Physique, Scars, Disabilities, Mental Stability Including Behaviour, Etc.):

ASSESSMENT AND RECOMMENDATIONS : FIT ALL AREAS FIT WITH RESTRICTION TEMPORARY UNFIT
 UNFIT

DR. SANATH BUDDHIKA PRIYADARSHAN
GENERAL PRACTITIONER

Date: 12/11/2023 Name (Block Capitals). Dr. Dr-Buddhi

Signature:

REVIEW/CONSULTATION:

Date: 12/11/2023 Name (Block Capitals). Dr.

Signature:

