

#1294

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

DOB
04/01/1965
CML-799 57 211
RHC

العيادة الرسمية
RUSAYL HEALTH CENTRE
NIMR, FAHUD, QARNALAM, BHAJA, SAHRIWAL, MARWAL

INITIAL EXAMINATION REPORT

Place of examination

Date 28/04/19

RS PAC CLINIC BAHJA

Surname PULICKAL BOULOSE

Forenames PAUL

Address TRUCK OMAN

Staff - 799 57 216

Home Telephone number 97122559

If a dependant or fiancee entr employee's name here :-

Surname :

Forenames:

		Nationality INDIAN	Country of birth INDIA	Religion CHRISTIAN
<input checked="" type="checkbox"/> Male	<input checked="" type="checkbox"/> Single	<input checked="" type="checkbox"/> Widow(er)	<input checked="" type="checkbox"/> Wife	Relationship to employee
<input checked="" type="checkbox"/> Female	<input checked="" type="checkbox"/> Married	<input checked="" type="checkbox"/> Divorced Separated	<input type="checkbox"/> Son	<input checked="" type="checkbox"/> Daughter <input checked="" type="checkbox"/> Fiancee

Reason for examination	<input checked="" type="checkbox"/> Pre-employment	Job :- DRIVER
	<input type="checkbox"/> Pre-overseas	Area:- BAHJA

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 ailments.)

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

How much tobacco each day? Non-Smoker

Average daily alcohol consumption

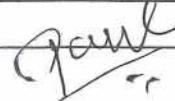
Family history	<input checked="" type="checkbox"/> Diabetes	<input checked="" type="checkbox"/> Tuberculosis	<input checked="" type="checkbox"/> Epilepsy	<input checked="" type="checkbox"/> Asthma	<input checked="" type="checkbox"/> Eczema	<input checked="" type="checkbox"/> Cancer	<input checked="" 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 28/04/19

Signature of applicant



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

N - Normal A - Abnormal Please Describe

N	A	
✓		1. Eyes & Pupils
✓		2. E.N.T.
✓		3. Teeth & Mouth
✓		4. Lungs & Chest
✓		5. Cardiovascular System
✓		6. Abdo. Viscera
✓		7. Hermal Orifices
✓		8. Anus & Rectum
✓		9. Genito - urinary
✓		10. Extremities
✓		11. Muscula-skeletal
✓		12. Skin & Varicose Vns.
✓		13. C.N.S.
✓		14. Breasts
		15.

PHYSICAL EXAMINATION

BMI - 27.0 kg/m²
HR - 86 b/min



HEIGHT cm	WEIGHT kg	B.P.	HEARING L	HEARING R	VISION: Uncorrected	DISTANT R L	NEAR R L	COLOUR VISION	BLOOD GROUP
177	84.5	157/86	(R)	(R)	Corrected	(R) (L)	(R) (L)		

LABORATORY AND SPECIAL INVESTIGATIONS

N	A	
✓	1. Urimalysis	PBS - 138 mg/dl
✓	2. Hb Bloodcount ESR	Urine Sugar (+)
✓	3. Sarum Profile	TG - 225 mg/dl
✓	4. Stool	TOL - 136.51 mg/dl
✓	5. E.C.G.	

OTHER FINDINGS (physique, scars, disabilities, mental stability etc.)

BMI - 27.0 kg/m²

Adv

- ✓ Repeat PBS to exclude DM
- ✓ Regular exercise
- ✓ Weight reduction
- ✓ Take plenty of fruits & vegetables

ASSESSMENT

FIT ALL AREAS

FIT HOME SERVICES ONLY

UNFIT/UNSUITABLE

MAY BE REASSESSED

Date 29.04.19

Signature

DR. HASAN MAHBUB KHAN BAYZID

Name (Block Capitals)

MEDICAL OFFICER

RUSAYL HEALTH CENTRE

MOH LIC NO. 15691

Doctor / Sister

REVIEW/CONSULTATION

Date

03.05.19

DR. HASAN MAHBUB KHAN BAYZID
MEDICAL OFFICER
RUSAYL HEALTH CENTRE
MOH LIC NO. 15691

On 03.05.19, Hb TMT was found to be positive. Consequently, coronary angiogram was advised, which was done on 20.05.19 in India (LSL Hospital) and the report of coronary angiogram came normal. Therefore he was mentioned **FIT TO WORK**. (Hb angiogram & TMT reports are attached)

Signature

Name (Block Capitals)

