



RUSAYL HEALTH CENTRE

ISO 9001-2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Place of examination

Gahra PAC
Clinic, NINJ

Date 16/06/2021

If a dependant enter employee's name here:

Surname:

Birth date: 01/01/1968

Nationality: Omani

Male Female

Married Single Separated /Divorced

Relationship to employee

Wife Son Daughter

Number of children: 10

Reason for examination

Routine

Pre-Employment

Job:

Field Operation Manager
Truck Driver /NINJ

Pre-Overseas

Area:

Name and address of family doctor

List your last 3 jobs

(1)

(2)

Are you a Registered Disabled Person? (UK only)

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

How much tobacco each day?

Average daily alcohol consumption

Have you ever taken elicited drugs? () PDO test all new/potential employees for elicited/recreational drugs

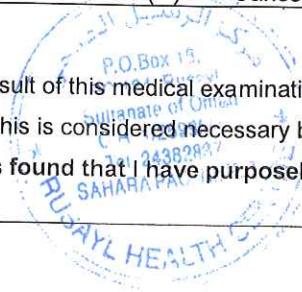
FAMILY HISTORY:	Diabetes ()	Tuberculosis ()	Epilepsy ()	Asthma ()	Eczema ()
Heart disease ()	High blood pressure ()	Stroke ()	Blood Disease ()	Cancer ()	

PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT:-

I declared these statements to be true to the best of my knowledge and belief and I agree that the result of this medical examination 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. I am also aware that PDO reserve the right to dismiss me if it was found that I have purposely withheld important medical information.

16/06/2021

Signature of Applicant:



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 /mins.	HEARING L Normal R Normal	VISION DISTANT Uncorrected Corrected	VISION NEAR R L 6/6	Colour Vision	Blood Group
143	98	32.7	124/86	80	Normal	6/6	6/6	Normal	

N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A
✓	1. Urinalysis	FBS - 130 mg/dl		7. Audiogram
✓	2. Hb, Bloodcount, ESR			8. Lung Function
✓	3. LFT, RFT, RBS	TC - 224		9. Chest X-Ray
	4. Drug Screen		✓	10. ECG
✓	5. Lipids (40 years +)		✓	11. CVS risk for 40 yrs. & above
✓	6. Sickle Cell test			12. HIV, Hepatitis screening

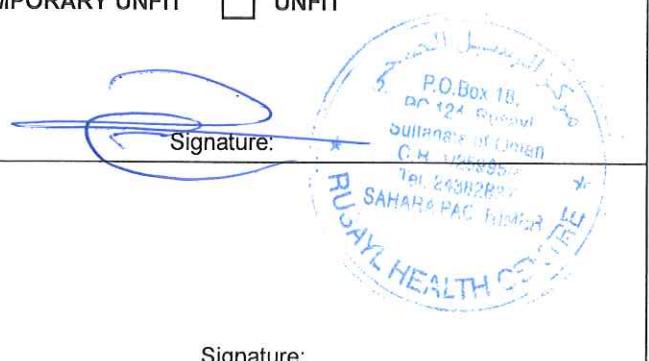
OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)

Advised on weight reduction, diet control, FBS monthly, regular exercise.

ASSESSMENT:

FIT ALL AREAS FIT WITH RESTRICTION TEMPORARY UNFIT UNFIT

16/06/2021
Date:
DR. SANATH BUDDHIKA PRIYADARSHAN
GENERAL PRACTITIONER
RUSAYL HEALTH CENTRE
MOH LIC NO. 16042



Date: Name (Block Capitals): Dr. / Nurse Signature: