

Routine

INITIAL EXAMINATION REPORT (MEDICAL - CONFIDENTIAL) No. A 2058



RUSAYL HEALTH CENTRE  
ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL  
DETAILS IN BLOCK CAPITALS

Place of examination: <u>Sahara PAC Clinic, Niny</u>	Date: <u>16/06/2021</u>	Home telephone number: <u>95308003</u>
If a dependant enter employee's name here: Surname: <u>S34/ID-915581/EMP-27</u>		Forenames: <u>Al Batahari</u>
Birth date: <u>01/01/1968</u>	Nationality: <u>Omani</u>	Country of birth: <u>Oman</u>
Religion: <u>Islam</u>	Relationship to employee: <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	Number of children: <u>10</u>
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced	

Reason for examination: <u>Routine</u>	Pre-Employment <input type="checkbox"/>	Job: <u>Field Operation Manager</u>
Pre-Overseas <input type="checkbox"/>	Area: <u>Trackman / Niny</u>	

Name and address of family doctor	List your last 3 jobs
	(1)
	(2)

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

How much tobacco each day?	Average daily alcohol consumption
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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 ( )

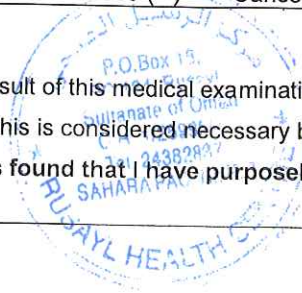
PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT:-

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

Date:

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	HEARING L Normal R Normal	VISION DISTANT R L / R L / Uncorrected 6/6 6/6 Corrected 10 10	Colour Vision normal
173	98	32.7	124/80 86	80/min.			
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS				N	A
✓		1. Urinalysis	FBS - 130 mg/dl				
✓		2. Hb, Bloodcount, ESR	7C - 224				
	✓	3. LFT, RFT, RBS					
		4. Drug Screen					
	✓	5. Lipids (40 years +)					
✓		6. Sickie 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.)

Advised on weight reduction, Diet control, FBS monthly, Regular Exercise.

ASSESSMENT:

☒ FIT ALL AREAS ☐ FIT WITH RESTRICTION ☐ TEMPORARY UNFIT ☐ UNFIT

Date: 16/06/2021  
Name (Block Capitals): DR. SANATH BUDDHIKA PRIYADARSHAN  
GENERAL PRACTITIONER  
RUSAYL HEALTH CENTRE  
MOH LIC NO. 16045

Signature: [Signature]  
P.O. Box 18,  
PO 124, Rusayl  
Sultanate of Oman  
C.H. 125555  
Tel. 24382897  
RUSAYL HEALTH CENTRE

REVIEW/CONSULTATION

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

Signature: