

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE
ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Surname/
Forenames: AbuTawheed Moham Pd
Hasan Al Balushi

Nationality: Oman

Company Number: 36

Reference Indicator:

Mobile No: 99355512

Home/Leave Address: Barha

Personal Details

S2 Y

Dob: 30/12/1969 FID: 1468152

A Male Female

Married Single Separated /Divorced /Widow(er)

Home/Leave Address:

Relationship to employee

Wife Son Daughter

No of Children: 0 S

Reason for Examination (tick as appropriate)

Periodic Medical Examination

Final / Retirement

Other Reason:

Employee only

B Present Job and Location:

Supervisor

Next Job and Location:

NIMV

Are you a registered person with special needs?

Do you belong to any Medical Insurance Scheme?

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

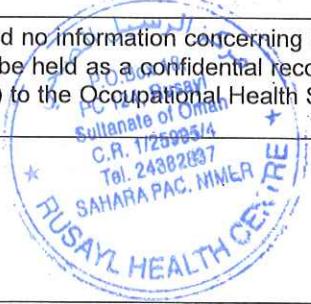
| | N | Y | Description |
|--|---|---|-------------------|
| Have you, since your last medical been treated by your family doctor or specialist for significant (major) ailments? | | ✓ | |
| 1 Ear, nose, eye or throat problems | | ✓ | |
| 2 Chest problems like asthma, bronchitis, other bad cough | | ✓ | |
| 3 Heart abnormality, chest pains | | ✓ | |
| 4 Abdominal pains, abnormal bowel motions | | ✓ | |
| 5 Urogenital problems (kidney disease, menstrual disorder) | | ✓ | |
| 6 Skin trouble or allergies | | ✓ | |
| 7 Epileptic fits, dizzy spells or migraine | | ✓ | |
| 8 History of mental illness, depression anxiety | | ✓ | |
| 9 Diabetes, thyroid disease | | ✓ | DM / on follow up |
| 10 Blood disorder e.g. anaemia, blood cancer e.g. leukaemia | | ✓ | |
| 11 Any history of accidents or fractures | | ✓ | |
| 12 Have you had any serious allergies | | ✓ | |
| 13 Do any dependants have a significant ongoing illness? | | ✓ | |
| 14 Any family history of cancers | | ✓ | DM / HTN |
| Do you take any regular medicines, or have you taken in the past? | | ✓ | |
| Do you smoke? If yes, what and how much each day? | | ✓ | |
| Do you drink alcohol? If yes, what is your average weekly intake? | | ✓ | |
| Have you ever taken elicited/recreational drugs? | | ✓ | |
| Are you doing regular sports or physical activities? | | ✓ | |

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. I 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.

DO NOT SIGN IF ANY INFORMATION IS
GENERAL PRACTITIONER
RUSAYL HEALTH CENTRE
MOH LIC NO. 20062

Signature of Applicant:

Wahab



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"/> | | 1. Eyes & Pupils | | 3 (N/A) | | | | | |
| <input checked="" type="checkbox"/> | | 2. E.N.T. | | | | | | | |
| <input checked="" type="checkbox"/> | | 3. Teeth & Mouth | | | | | | | |
| <input checked="" type="checkbox"/> | | 4. Lungs & Chest | | | | | | | |
| <input checked="" type="checkbox"/> | | 5. Cardiovascular System | | | | | | | |
| <input checked="" type="checkbox"/> | | 6. Abdo. Viscera | | | | | | | |
| <input checked="" type="checkbox"/> | | 7. Hernial Orifices | | | | | | | |
| <input checked="" type="checkbox"/> | | 8. Anus & Rectum | | | | | | | |
| <input checked="" type="checkbox"/> | | 9. Genito-urinary | | | | | | | |
| <input checked="" type="checkbox"/> | | 10. Extremities | | | | | | | |
| <input checked="" type="checkbox"/> | | 11. Musculo-skeletal | | | | | | | |
| <input checked="" type="checkbox"/> | | 12. Skin & Varicose Vns. | | | | | | | |
| <input checked="" type="checkbox"/> | | 13. C.N.S. | | | | | | | |
| HEIGHT cm 171 | | WEIGHT kg 128 | BMI 43 | B.P. 128 88 | PULSE 79 mins. | HEARING L R Normal Normal Uncorrected Corrected | DISTANT R L 6/6 | VISION R L 6/6 | |
| N | A | LABORATORY AND OTHER SPECIAL INVESTIGATIONS | | | | N | A | | |
| <input checked="" type="checkbox"/> | | 1. Urinalysis TBS - 212 | | | | | | 7. Audiogram | |
| <input checked="" type="checkbox"/> | | 2. Hb, Bloodcount, ESR FBS - 169 | | | | | | 8. Lung Function | |
| <input checked="" type="checkbox"/> | | 3. LFT, RFT, RBS FBS - 135mHb. | | | | | | 9. Chest X-Ray | |
| <input checked="" type="checkbox"/> | | 4. Drug Screen | | | | | | 10. ECG | |
| <input checked="" type="checkbox"/> | | 5. Lipids (40 years +) | | | | | | 11. CVS risk for 40 yrs. & above | |
| <input checked="" type="checkbox"/> | | 6. Sickle Cell test | | | | | | 12. HIV, Hepatitis screening | |

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

Torvast 10mg daily, weight lost & regular sugar monitoring (weekly FBS and 3 monthly HbA1c) advised.

ASSESSMENT AND RECOMMENDATIONS:

FIT ALL AREAS FIT WITH RESTRICTION TEMPORARY UNFIT UNFIT

DR. INNOCENT IFEANYI NWOKEDIUKO
GENERAL PRACTITIONER
RUSAYL HEALTH CENTRE
MOHIC NO. 2002

Date:

Signature:

REVIEW/CONSULTATION

Date:

Name (Block Capitals): Dr. / Nurse

Signature: