

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE
ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Surname/ Forenames		SAIF SALIM MOHAMMED AL SHUAILE	
Nationality		45/m/ Omani	
Company Number:		502	Reference Indicator:

Mobile No. 99759984	Home/Leave Address:	Civil ID # 7377384	
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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 /Widow(er)
Home/Leave Address:	Relationship to employee <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter
Reason for Examination (tick as appropriate)	
Periodic Medical Examination <input checked="" type="checkbox"/> Final / Retirement <input type="checkbox"/> Other Reason: <input type="checkbox"/>	

Employee only	
B Present Job and Location: Rig more Sup. / Marmul	
Are you a registered person with special needs? <input type="checkbox"/>	Next Job and Location: Rig more Sup. - Truk Oman Do you belong to any Medical Insurance Scheme? <input type="checkbox"/>
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 <input checked="" type="checkbox"/>		
2	Chest problems like asthma, bronchitis, other bad cough <input checked="" type="checkbox"/>		
3	Heart abnormality, chest pains <input checked="" type="checkbox"/>		
4	Abdominal pains, abnormal bowel motions <input checked="" type="checkbox"/>		
5	Urogenital problems (kidney disease, menstrual disorder) <input checked="" type="checkbox"/>		
6	Skin trouble or allergies <input checked="" type="checkbox"/>		
7	Epileptic fits, dizzy spells or migraine <input checked="" type="checkbox"/>		
8	History of mental illness, depression anxiety <input checked="" type="checkbox"/>		
9	Diabetes, thyroid disease <input checked="" type="checkbox"/>		
10	Blood disorder e.g. anaemia, blood cancer e.g. leukaemia <input checked="" type="checkbox"/>		
11	Any history of accidents or fractures <input checked="" type="checkbox"/>		
12	Have you had any serious allergies <input checked="" type="checkbox"/>		
13	Do any dependants have a significant ongoing illness? <input checked="" type="checkbox"/>		
14	Any family history of cancers <input checked="" type="checkbox"/>		
Do you take any regular medicines, or have you taken in the past? <input checked="" type="checkbox"/>			
Do you smoke? If yes, what and how much each day? <input checked="" type="checkbox"/>			
Do you drink alcohol? If yes, what is your average weekly intake? <input checked="" type="checkbox"/>			
Have you ever taken elicited/recreational drugs? <input checked="" type="checkbox"/>			
Are you doing regular sports or physical activities? <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. 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.

18 june 2023

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 /mins.	HEARING L (N) R (N)	VISION	
						DISTANT R L	NEAR R L
158	73	29.2	110 / 70	71	Uncorrected Corrected	6/6 6/6	6/6 6/6

N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS		N	A
✓		1. Urinalysis			7. Audiogram
✓		2. Hb, Bloodcount, ESR			8. Lung Function
✓		3. LFT, RFT, RBS			9. Chest X-Ray
✓		4. Drug Screen		✓	10. ECG
✓		5. Lipids (40 years +)		✓	11. CVS risk for 40 yrs. & above 5.67
✓		6. Sickle Cell test			12. HIV, Hepatitis screening

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

A Overweight, Impaired fasting glucose; Framingham 5.68 low-risk

ASSESSMENT AND RECOMMENDATIONS:

FIT ALL AREAS

FIT WITH RESTRICTION

TEMPORARY UNFIT

UNFIT

18 June 2023

DR. ROMMER WHIGAN MELIENDRES
GENERAL PRACTITIONER
RUSAYL HEALTH CENTRE
MOHILIC NO. 13982

Date:

Name (Block Capitals): Dr. / Nurse

Signature: SAHARA NIMR
RUSAYL HEALTH CENTRE
C.R. No.: 1259954, I.T. No.: 124, Sultanate of Oman

REVIEW/CONSULTATION

P, Weight management; Diabetic diet for 3 months monitor FBS monthly, exercise; monitor weight regularly; Refer accordingly

Date:

Name (Block Capitals): Dr. / Nurse

Signature: Jm