

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE  
ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Mobile No. 956 56 758 79	Home/Leave Address:	Surname/Forenames SULAIMAN MOHAMMED
		SURUR AL JABRI
		40/m/ Omani
	Company Number: 998	Reference Indicator:

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 <input type="checkbox"/> Widower(er)
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Home/Leave Address:	Relationship to employee	No of Children: 4
	<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"/>
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Employee only

B Present Job and Location: Asst Supervisor - Marmul	Next Job and Location: Asst Supervisor - Truck Oman
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Are you a registered person with special needs? <input type="checkbox"/>	Do you belong to any Medical Insurance Scheme? <input type="checkbox"/>
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**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?			

**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.

Date: 30 April 2023	Signature of Applicant:
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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	Tachycardia initially 110 → 100 → 98
✓	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. 150 90	PULSE /mins. 127	HEARING L (N) R (N)	DISTANT R L	NEAR R L	VISION
160	78	30.5	↳ 130 90	↳ 110 → 98	Uncorrected Corrected	6/6	6/6	6/6

N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A
✓	1. Urinalysis	FBS 158, SGPT 42 Tn <sup>3</sup> 214, TC 208		7. Audiogram
✓	2. Hb, Bloodcount, ESR			8. Lung Function
✓	3. LFT, RFT, RBS			9. Chest X-Ray
	4. Drug Screen		✓	10. ECG ST
✓	5. Lipids (40 years +)		✓	11. CVS risk for 40 yrs. & above 672
✓	6. Sickle Cell test			12. HIV, Hepatitis screening

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

A. Obesity, impaired fasting glucose, Dyslipidemia; slightly elevated liver enzymes without clinical symptoms, Consider Hypertriglyceridemia

## ASSESSMENT AND RECOMMENDATIONS:

FIT ALL AREAS [ ]

Date: \_\_\_\_\_ Name: \_\_\_\_\_

Name (Block Capitals): Dr. / Nurse

مركز الرسیل الصحیح  
 UNFIT  
**RUSAYL HEALTH CENTRE**  
 دریج نام: 1259954 | تاریخ: ٢٠٢٣-٠٦-١٥  
 P.G. Box : 18, P.C.: 124, Rusayl  
 Sultanate of Oman  
 Signature: **SAHARA NIMR**

## REVIEW/CONSULTATION

P> Low-fat diet, exercise, Thervore fluid intake; Monitor FBS monthly, Repeat lipid profile & liver function test on Sep 7 2023; monitor BP weekly to monthly basis

Date: 10/10/10 Name (Block Capitals): Dr. / Nurse

Signature:

✓

30 April 2023