



مركز الرسيل الصحي RUSAYL HEALTH CENTRE

ISO 9001 - 2015 Certified Co.

No. B 14890

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE
ISO 9001 - 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Surname/
Forenames **MUSABAH GASIM SULAIMAN**

Nationality **SA'UD AL ZAHLI**

Company Number: **611**

Reference Indicator:

Mobile No. **92355881**

Home/Leave Address:

Civil ID # 2288201

Personal Details

A ☒ Male ☐ Female

☒ Married ☐ Single ☐ Separated /Divorced /Widow(er)

Home/Leave Address:

Relationship to employee

☐ Wife ☐ Son ☐ Daughter

No of Children: **5**

Reason for Examination (tick as appropriate)

Periodic Medical Examination ☒ Final / Retirement ☐ Other Reason: ☐

Employee only

B Present Job and Location:

Supervisor - Nimir

Next Job and Location:

Supervisor - Truck Oman

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	<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"/>		① DM II on OHA
11 Any history of accidents or fractures	<input checked="" type="checkbox"/>		
12 Have you had any serious allergies	<input checked="" type="checkbox"/>		① Disk surgery 20 yrs ago
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 your 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 .

Date: **11 June 2023**

Signature of Applicant:

[Signature]



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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
✓		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 R	VISION			
						DISTANT		NEAR	
						R	L	R	L
170	115	39.8	120 60	75	(N) (N)	Uncorrected Corrected	6/6 6/6	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	Hgb 13.7			8. Lung Function
	✓	3. LFT, RFT, RBS	FBS 150			9. Chest X-Ray
		4. Drug Screen	Urea 50	✓		10. ECG
✓		5. Lipids (40 years +)		✓		11. CVS risk for 40 yrs. & above 7.92
✓		6. Sickie Cell test				12. HIV, Hepatitis screening

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

As Obesity; Diabetes mellitus Type 2, mild anemia +
slightly elevated urea without clinical symptoms, Framingham
7.92 low-risk

ASSESSMENT AND RECOMMENDATIONS:

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

11 June 2023

DR. RUMEL WHIGAN MELORES
GENERAL PRACTITIONER
RUSAYL HEALTH CENTRE
MOBILE NO. 13982

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

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RUSAYL HEALTH CENTRE
C.R. No.: 1259954, 1701101
P.O. Box: 18, P.C.: 124, Rusayl
Sultanate of Oman

REVIEW/CONSULTATION

As Weight management, monitor weight regularly; Continue Diabetes
medications; monitor FBS monthly; Iron supplement till or
Iron-rich food for 3 months; Increase fluid intake;
Repeat CBE + RFT after 3 months
May start treatment as my oo (Statin-indicated)

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

11 June 2023