



مركز الرسيل الصحي RUSAYL HEALTH CENTRE

ISO 9001 - 2015 Certified Co.

No. B 08191

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE
ISO 9001 - 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Surname/
Forenames

Hamed Salim Nasser
Al Salehi

Nationality

Omani

Company Number:

749

Reference Indicator:

Typhoon

Mobile No.

99073313

Home/Leave Address:

Surair

Personal Details

48y 1703 - 11,08,1973 ID - 2256574

A ☒ Male ☐ Female

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

Home/Leave Address:

Relationship to employee

☐ Wife ☐ Son ☐ Daughter

No of Children: 02

Reason for Examination (tick as appropriate)

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

Employee only

B Present Job and Location:

Foreman

Next Job and Location:

Nina / Murru

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

20/06/2021

Signature of Applicant:

Hm





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
<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	WEIGHT kg	BMI	B.P.	PULSE	HEARING	VISION
153	74	31.6	118/82	67/min.	L Normal R Normal	DISTANT R L Uncorrected 6/6 Corrected 6/6

N	A		LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A	
<input checked="" type="checkbox"/>		1. Urinalysis	T6 - 201	<input checked="" type="checkbox"/>		7. Audiogram
<input checked="" type="checkbox"/>		2. Hb, Bloodcount, ESR		<input checked="" type="checkbox"/>		8. Lung Function
<input checked="" type="checkbox"/>		3. LFT, RFT, RBS		<input checked="" type="checkbox"/>		9. Chest X-Ray
<input checked="" type="checkbox"/>		4. Drug Screen		<input checked="" type="checkbox"/>		10. ECG
<input checked="" type="checkbox"/>		5. Lipids (40 years +)		<input checked="" type="checkbox"/>		11. CVS risk for 40 yrs. & above
<input checked="" type="checkbox"/>		6. Sickie Cell test		<input checked="" type="checkbox"/>		12. HIV, Hepatitis screening

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

A2V1S2 on aortic DE 2nd rib, low for age, regular P2 aortic.

ASSESSMENT AND RECOMMENDATIONS:

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

Date:

Name (Block Capitals): Dr. / Nurse

Signature:

REVIEW/CONSULTATION

Date:

Name (Block Capitals): Dr. / Nurse

Signature:

