

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE
ISO 9001-2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Surname/
Forenames

TALAL SAID HUMAID (35 yrs)

Nationality

OMANI

Mobile No. 92617076

Home/Leave Address:

Company Number: 10016

Reference Indicator:

DOB - 31/03/1986

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: TAEEN OMAN	Relationship to employee <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter
No of Children: 4	

Reason for Examination (tick as appropriate)

Periodic Medical Examination Final / Retirement Other Reason:

Employee only

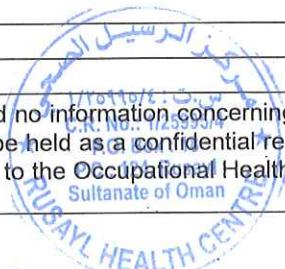
B Present Job and Location: SUPERVISER, TRUCKMAN, NIMR	Next Job and Location: NIMR
Are you a registered person with special needs? <input type="checkbox"/>	Do you belong to any Medical Insurance Scheme? <input type="checkbox"/>

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.



Date: 13-06-2024

Signature of Applicant:

FOR COMPLETION BY EXAMINING DOCTOR OR NURSE

Further details of medical history and recreational activities

TALAL SAID HUMAID (35 yrs)

N = Normal A = Abnormal (please describe)		PHYSICAL EXAMINATION													
N	A														
✓		1. Eyes & Pupils													
✓		2. E.N.T.													
✓	✓	3. Teeth & Mouth			'Cavity teeth - 2'										
✓		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. 120/ 80 kg/m ²	PULSE 70 /mins.	HEARING L R	Uncorrected Corrected	VISION							
173		67	22.39			R L		DISTANT R L	NEAR R L						
								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 FBS							9. Chest X-Ray <i>Not done</i>						
		4. Drug Screen					<i>Not done</i>		10. ECG						
✓		5. Lipids (40 years +)							11. CVS risk for 40 yrs. & above						
✓		6. Sickle Cell test					<i>Negative</i>		12. HIV, Hepatitis screening						
OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)															
<ul style="list-style-type: none"> <i>Cavity teeth - 2</i> <i>No other physical or mental abnormality found.</i> 															
ASSESSMENT AND RECOMMENDATIONS:															
<input checked="" type="checkbox"/> FIT ALL AREAS		<input type="checkbox"/> FIT WITH RESTRICTION		<input type="checkbox"/> TEMPORARY UNFIT		<input type="checkbox"/> UNFIT									
13.06.2021		DR. MOHAMMAD HARUN AR RASHID						 Signature:							
Date:		Name (Block Capitals): Dr. / Nurse													
REVIEW/CONSULTATION								DR. MOHAMMAD HARUN AR RASHID MEDICAL OFFICER RUSAYL HEALTH CENTRE MOH LIC NO. 555							
Date:		Name (Block Capitals): Dr. / Nurse						Signature:							