



# مركز الرسيل الصحي RUSAYL HEALTH CENTRE

ISO 9001- 2015 Certified Co.

No. B15235

## ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



### RUSAYL HEALTH CENTRE

ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL  
DETAILS IN BLOCK CAPITALS

Surname/ Forenames	Badar Hamaid Salim Al Ghadani
Nationality	OMani
Company Number:	10065
Reference Indicator:	7 yurk super

Mobile No.	92149673	Home/Leave Address:	Sunair
Personal Details	37 y	DOB - 24.01.1985	ID - 14565626
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	No of Children:	
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:	Next Job and Location:
operator	NIMV

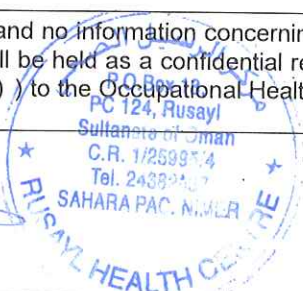
Are you a registered person with special needs? <input type="checkbox"/>	Do you belong to any Medical Insurance Scheme? <input type="checkbox"/>
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**Previous Medical History:** All important medical events should be listed and dated at every medical 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			
2	Chest problems like asthma, bronchitis, other bad cough			
3	Heart abnormality, chest pains			
4	Abdominal pains, abnormal bowel motions			
5	Urogenital problems (kidney disease, menstrual disorder)			
6	Skin trouble or allergies			
7	Epileptic fits, dizzy spells or migraine			
8	History of mental illness, depression anxiety			
9	Diabetes, thyroid disease			
10	Blood disorder e.g. anaemia, blood cancer e.g. leukaemia			
11	Any history of accidents or fractures			
12	Have you had any serious allergies			
13	Do any dependants have a significant ongoing illness?			
14	Any family history of cancers			
Do you take any regular medicines, or have your taken in the past?				
Do you smoke? If yes, what and how much each day?				
Do you drink alcohol? If yes, what is your average weekly intake?				
Have you ever taken elicited/recreational drugs?				
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:	18/04/2022
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
		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	HEARING	VISION
162	79	30	110/78	80 mins.	L Normal R Normal	DISTANT R L Uncorrected Corrected

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
		6. Sickie Cell test				12. HIV, Hepatitis screening

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

Advised on weight reduction.

## ASSESSMENT AND RECOMMENDATIONS:

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

18/04/2022  
Date: Name (Block Capitals): Dr. / Nurse  
DR. SANATH BUDDHIKA PRIYADARSHAN  
GENERAL PRACTITIONER  
RUSAYL HEALTH CENTRE  
MOH LIC NO. 46042

Signature:

## REVIEW/CONSULTATION

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

Signature:

