

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE

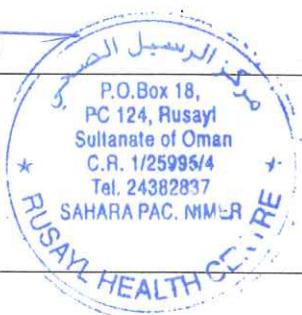
ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

<b>Mobile No.</b> 92690977 <b>Home/Leave Address:</b> Sunayla		<b>Surname/Forenames</b> Saad Ahmed Rashid <b>Nationality</b> AI Batinshi, Omani																																																																																																
<b>Personal Details</b> 399   DOB - 12/07/1982   ID - 12427369		<b>Company Number:</b> 8008 <b>Reference Indicator:</b> Frenchman																																																																																																
<b>A</b> <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced /Widow(er)																																																																																																
<b>Home/Leave Address:</b>		<b>Relationship to employee</b> <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter																																																																																																
<b>Reason for Examination</b> (tick as appropriate) <input type="checkbox"/> Periodic Medical Examination <input checked="" type="checkbox"/> Final / Retirement <input type="checkbox"/> Other Reason: _____																																																																																																		
<b>Employee only</b> <b>B</b> Present Job and Location: Foreman / LDI   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"/>																																																																																																
<b>Previous Medical History:</b> 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.																																																																																																		
<b>Please answer the following questions and tick 'N' (no) or 'Y' (yes) in the column. If 'Y' Please describe</b>																																																																																																		
<table border="1"> <thead> <tr> <th></th> <th>N</th> <th>Y</th> <th>Description</th> </tr> </thead> <tbody> <tr> <td>Have you, since your last medical been treated by your family doctor or specialist for significant (major) ailments?</td> <td></td> <td></td> <td></td> </tr> <tr> <td>1 Ear, nose, eye or throat problems</td> <td></td> <td></td> <td></td> </tr> <tr> <td>2 Chest problems like asthma, bronchitis, other bad cough</td> <td></td> <td></td> <td></td> </tr> <tr> <td>3 Heart abnormality, chest pains</td> <td></td> <td></td> <td></td> </tr> <tr> <td>4 Abdominal pains, abnormal bowel motions</td> <td></td> <td></td> <td></td> </tr> <tr> <td>5 Urogenital problems (kidney disease, menstrual disorder)</td> <td></td> <td></td> <td></td> </tr> <tr> <td>6 Skin trouble or allergies</td> <td></td> <td></td> <td></td> </tr> <tr> <td>7 Epileptic fits, dizzy spells or migraine</td> <td></td> <td></td> <td></td> </tr> <tr> <td>8 History of mental illness, depression anxiety</td> <td></td> <td></td> <td></td> </tr> <tr> <td>9 Diabetes, thyroid disease</td> <td></td> <td></td> <td></td> </tr> <tr> <td>10 Blood disorder e.g. anaemia, blood cancer e.g. leukaemia</td> <td></td> <td></td> <td></td> </tr> <tr> <td>11 Any history of accidents or fractures</td> <td></td> <td></td> <td></td> </tr> <tr> <td>12 Have you had any serious allergies</td> <td></td> <td></td> <td></td> </tr> <tr> <td>13 Do any dependants have a significant ongoing illness?</td> <td></td> <td></td> <td></td> </tr> <tr> <td>14 Any family history of cancers</td> <td></td> <td></td> <td></td> </tr> <tr> <td colspan="4">Do you take any regular medicines, or have you taken in the past?</td> </tr> <tr> <td colspan="4">Do you smoke? If yes, what and how much each day?</td> </tr> <tr> <td colspan="4">Do you drink alcohol? If yes, what is your average weekly intake?</td> </tr> <tr> <td colspan="4">Have you ever taken elicited/recreational drugs?</td> </tr> <tr> <td colspan="4">Are you doing regular sports or physical activities?</td> </tr> <tr> <td colspan="4"> <b>STATEMENT:</b> 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.         </td> </tr> <tr> <td colspan="2"> <b>Date:</b> 12/10/2021  </td> <td colspan="2"> <b>Signature of Applicant:</b> </td> </tr> <tr> <td colspan="4"> </td> </tr> </tbody> </table>				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 you 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?				<b>STATEMENT:</b> 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.				<b>Date:</b> 12/10/2021		<b>Signature of Applicant:</b>					
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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	7										
		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	Normal Uncorrected Corrected	DISTANT R L	VISION NEAR R L					
171	87	29.8	110 84	68			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						9. Chest X-Ray					
		4. Drug Screen						10. ECG					
		5. Lipids (40 years +)						11. CVS risk for 40 yrs. & above					
		6. Sickle Cell test						12. HIV, Hepatitis screening					
OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.) A 2 rise 2 on oral on a relaxation.													
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							
12/10/2021				DR SANATH BUDDHIKA PRIYADARSHAN GENERAL PRACTITIONER RUSAYL HEALTH CENTRE IC NO. 16042									
Date:	Name (Block Capitals): Dr. / Nurse							Signature:					
REVIEW/CONSULTATION													
Date:	Name (Block Capitals): Dr. / Nurse							Signature:					
 <p>P.O.Box 18, PC 124, Rusayl Sultanate of Oman C.R. 1/25996/4 Tel. 24382837 SAHARA PAC. NIMR</p>													