



ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



**RUSAYL HEALTH CENTRE**  
ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Mobile No. 99570047	Home/Leave Address:	Company Number: 10059	Reference Indicator:
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Personal Details		D.O.B 13/08/82, 40 yrs.	
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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)
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Home/Leave Address:	<input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	No of Children: 5
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Reason for Examination (tick as appropriate)			
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Periodic Medical Examination <input checked="" type="checkbox"/>	Final / Retirement <input type="checkbox"/>	Other Reason: <input type="checkbox"/>
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Employee only			
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B Present Job and Location: MML OPERATOR	Next Job and Location:
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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.

	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?	✓		

**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: 17/09/22

Signature of Applicant:



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			
176	96.4	31.1	110 70	78/mins.	L R N	DISTANT Uncorrected Corrected	R L	R L	R 6/4 L 6/4

N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A
✓	1. Urinalysis	↑ PSUPT/SUOT, May be due to fatty liver. Ref To LIV 52 Off H-3/2		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.)**

scars, disabilities, mental stability including behaviour, etc.)  
TMT Done & Confirmed by Cardiologist  
(Normal) to be fit to work in PDO

## ASSESSMENT AND RECOMMENDATIONS:

FIT ALL AREAS     FIT WITH RESTRICTION     TEMPORARY UNFIT     UNFIT

Date: 17/09/22 Name (Block Capitals): Dr. / Nurse

**DR. LIPON KANTI BARUA**  
GENERAL PRACTITIONER  
RUSAYL HEALTH CENTRE  
MOH TEL NO. 11557

Signature:

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Name (Block Capitals): Dr. / Nurse

Signature: