



ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE

ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Surname/ Forenames *FatSal Mu,look khudada*

Nationality *AI Balushi*

Company Number *8078* Reference Indicator: *Trukhuan*

Mobile No *98009113* Home/Leave Address: *Muscat*

Personal Details *43y 1 DOB 30/10/1978* ID *150-7397759*

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 / CDD* Next Job and Location: *Murmu*

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"/>		
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"/>	DM) on medications
Do you smoke? If yes, what and how much each day?	<input checked="" type="checkbox"/>		As abr C
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: <i>06/07/2021</i>	Signature of Applicant: <i>Alia</i>
<p style="text-align: right;">P.O.Box 18 PC 124 Rusayl Sultanate of Oman C.R. 1/25095 Tel. 24382837 SAHARA PAC. NIPAC</p> <p style="text-align: right;">RUSAYL HEALTH CENTRE</p>	

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 /mins.	HEARING L Normal R Normal Uncorrected Corrected	DISTANT R L	VISION NEAR R L
175	92	30	124/82	70		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.)

Advised to continue medications for DM
creatinine reduction, regular exercise, Diet (coughs).

ASSESSMENT AND RECOMMENDATIONS:

FIT ALL AREAS FIT WITH RESTRICTION TEMPORARY UNFIT UNFIT

or for medications & follow up.

Date: 06/07/2021

Name (Block Capitals): Dr. / Nurse

Signature:

REVIEW/CONSULTATION

DR. SANATH RUPDHika PRIYadarshan
GENERAL PRACTITIONER
RUSAYL HEALTH CENTRE
MOH LIC NO. 16042

Date:

Name (Block Capitals): Dr. / Nurse

Signature:

