



مكتب الرعاية بالصحي
RUSAYL HEALTH CENTRE
RENAISSANCE VILLAGE DUQM

INITIAL EXAMINATION REPORT

Place of examination NIMR Date 25/06/19

Surname GAIF AL HABSI	
Forenames TALAL GAIF GALIM	
Address TRUCK OMAN NIMR	
FIN: 8148	
Home Telephone number 95832197	

If a dependant or fiancee entr employees name jere :- FIN: 23494161 Age: 23 years

Surname:

	Nationality OMAN	Country of birth OMAN	Religion ISLAM	
<input checked="" type="checkbox"/> Male	<input type="checkbox"/> Single	<input type="checkbox"/> Widow(er)	Relationship to employee <input type="checkbox"/> Wife <input type="checkbox"/> Son <input checked="" type="checkbox"/> Daughter <input type="checkbox"/> Fiancee	Number of Children 01
<input type="checkbox"/> Female	<input checked="" type="checkbox"/> Married	<input type="checkbox"/> Divorced Separated		
Reason for examination	Pre-employment <input checked="" type="checkbox"/> ROUTINE <input type="checkbox"/> Pre-overseas	Job :- FOREMAN	Area:- NIMR	

Name and address of family doctor	List your last 3 jobs
	(1) FOREMAN
	(2) -
	(3) -

Are you Registered Disabled Person? (UK) Do you belong to any Medical Insurance Scheme?

DO YOU HAVE OR HAVE YOU HAD :- (Tick 'yes' or 'No' column or put a (?) It uncertain exclude minor ailmenis.)

Y	N	Y	N	Y	N
1. Sirius rouble	✓	22. Heart Disease	✓	42. Awarded benifities for Industrial injury/lillness	✓
2. Neck swellings/flands	✓	23. Rheumatic Fever	✓	43. Treated for a mental condition, eg . depression	✓
3. Difficulty in vision	✓	24. Abnormal heartbeat	✓	44. Treated for problem drinking or drug abuse	✓
4. Any ear discharge	✓	25. High blood pressure	✓	45. Exposed to toxic substance or noise	✓
5. Asthma/bronchitis	✓	26. Stroke	✓	FOR WOMEN ONLY	
6. Hayfever/other allergy	✓	27. Serious chest pain	✓	Have you ever had:-	
7. Any skin trouble	✓	28. Any blood disease	✓	46. An abnormal smear	
8. Tuberculosis	✓	29. Kidney disease	✓	47. Any gynaecological treatment	
9. Shortness of breath	✓	30. Painful passage of urine	✓	48. Are you pregnant?	
10. Coughed/vomited blood	✓	31. Blood in urine	✓	49. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE ?	
11. Severe abdominal pain	✓	32. Diabetes	✓		
12. Stomach ulcer	✓	33. Headaches /migraine	✓		
13. Recurrent indigestion	✓	34. Dizziness/tainting	✓		
14. Jaundice or hepatitis	✓	35. Epilepsy	✓		
15. Gall bladder disease	✓	36. Joints/spinal trouble	✓		
16. Marked change in bowel habits	✓	37. Surgical operation	✓		
17. Blood in stools (motions)	✓	38. Serious accident /fracture	✓		
18. Marked change in weight	✓	39. Tropical disease	✓		
19. Varicose veins	✓	40. Fear of heights	✓		
20. Lump in breast/armpit	✓	HAVE YOU EVER BEEN:-			
21. Cancer	✓	41. Rejected for employment or insurance for medical reasons	✓		

How much tabacco each day ?	Average daily alcohol consupotion					
Family history	Diabetes <input checked="" type="checkbox"/>	Tuberculosis <input type="checkbox"/>	Epilepsy <input type="checkbox"/>	Asthama <input type="checkbox"/>	Eczerna <input type="checkbox"/>	Blood disease <input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT :-
I declare these statements to be true to the best of my knowledge and belief and I agree that the result of this medical in general terms may be revealed to the company if required, and the details sent to my own doctor if this is considered necessary by the examining medical officer.

Date 25.06.2019

Signature of applicant

FOR COMPLETION BY EXAMINING DOCTOR OR SISTER
FURTHER DETAILS OF MEDICAL HISTORY AND RECREATIONAL ACTIVITIES

Talal Fair

Age: 27 years

N - Normal A - Abnormal Please Describe		PHYSICAL EXAMINATION								
N	A	Normal								
<input checked="" type="checkbox"/> 1. Eyes & Pupils <input checked="" type="checkbox"/> 2. E.N.T. <input checked="" type="checkbox"/> 3. Teeth & Mouth <input checked="" type="checkbox"/> 4. Lungs & Chest <input checked="" type="checkbox"/> 5. Cardiovascular System <input checked="" type="checkbox"/> 6. Abdo. Viscera <input checked="" type="checkbox"/> 7. Hernial Orifices <input checked="" type="checkbox"/> 8. Anus & Rectum <input checked="" type="checkbox"/> 9. Genito - urinary <input checked="" type="checkbox"/> 10. Extremities <input checked="" type="checkbox"/> 11. Muscula-skeletal <input checked="" type="checkbox"/> 12. Skin & Varicose Vns. <input checked="" type="checkbox"/> 13. C.N.S. <input checked="" type="checkbox"/> 14. Breasts 15.										
HEIGHT cm	WEIGHT kg	B.P.	HEARING L R	HEARING L R	VISION: Uncorrected Corrected	6 6	DISTANT R L 6 6 6	NEAR R L 6 6 6	COLOUR VISION N	BLOOD GROUP "
166	71	120/81 N/N	N	N						
		AM 1. 25.8 HR. 74 BPM, Regular.								
		N/A								
		LABORATORY AND SPECIAL INVESTIGATIONS								
<input checked="" type="checkbox"/> 1. Urinalysis <input checked="" type="checkbox"/> 2. Hb Bloodcount ESR <input checked="" type="checkbox"/> 3. Sarum Profile <input checked="" type="checkbox"/> 4. Stool <input type="checkbox"/> 5. E.C.G.		<input checked="" type="checkbox"/> 6. Audiogram <input checked="" type="checkbox"/> 7. Lung Function <input checked="" type="checkbox"/> 8. Chest X-Ray <input checked="" type="checkbox"/> 9. Drug Screen <input checked="" type="checkbox"/> 10. CR Screen								
OTHER FINDINGS (physique, scars, disabilities, mental stability etc.)										

N/A

ASSESSMENT

FIT ALL AREAS FIT HOME SERVICES ONLY UNFIT/UNSUITABLE MAY BE REASSESSED

Date 25.06.2019

Signature

DR. MD. MONIRUL AZIM

Name (Block Capitals)

Doctor / Sister

REVIEW/CONSULTATION

DR. MD MONIRUL AZIM
GENERAL PRACTITIONER
RUSAYL HEALTH CENTRE
MOH LIC NO. 14866

Date

Signature

Name (Block Capitals)

Doctor / Sister