

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE

ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Surname/Forenames		Said Ali Salaiman	
Nationality		Omani	
Company Number:		965	
		Reference Indicator: Truchoman	

Mobile No	99518836	Home/Leave Address:	Nahlae
Personal Details		41y 1203 01,04,1980	
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:	<input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	No of Children: 04
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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:
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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.

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 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?		<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: 06/11/2021	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			NAD						
		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	Uncorrected	Corrected	DISTANT R L	NEAR R L	VISION
163		63	23.7	110 82	68	Normy Normy			6/6	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.)											
NAD											
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					
<b>DR. SANATH BUDDHIKA PRIYADARSHAN</b> <b>GENERAL PRACTITIONER</b> <b>RUSAYL HEALTH CENTRE</b> <b>MOBILE NO. 16042</b>											
6/11/2021		Name (Block Capital): Dr. / Nurse		Signature							

## **ASSESSMENT AND RECOMMENDATIONS:**

FIT ALL AREAS  FIT WITH RESTRICTION  TEMPORARY UNFIT  UNFIT

Name (Block Capitals): Dr / Nurse

Signature:

## REVIEW/CONSULTATION

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

Signature:

