



مركز الرسيل الصحي RUSAYL HEALTH CENTRE

ISO 9001 - 2015 Certified Co.

7-10024

No. B 08280

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE
ISO 9001 - 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Surname/Forenames **MARHOUN SALEH HARI B AL YAHBOUBI**

Nationality **OMANI**

Mobile No. **92565282**

Home/Leave Address:

Company Number: **10024 TRUCK OMANI** Reference Indicator:

Personal Details **Age - 52yrs, DOB - 01/01/1969 Civil ID - 673297**

A ☒ Male ☐ Female

☒ Married ☐ Single ☐ Separated /Divorced /Widow(er)

Home/Leave Address:

Relationship to employee

☐ Wife ☐ Son ☐ Daughter

No of Children: **1**

Reason for Examination (tick as appropriate)

Periodic Medical Examination ☒ Final / Retirement ☐ Other Reason: ☐

Employee only

B Present Job and Location:

DRIVER

Next Job and Location:

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?			
1 Ear, nose, eye or throat problems	☒		
2 Chest problems like asthma, bronchitis, other bad cough	☒		
3 Heart abnormality, chest pains		☒	ON ANTI HYPERTENSIVE
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		☒	ON ORAL ANTI DIABETIC
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 your 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: **19-07-2021**

Signature of Applicant:

[Signature]



FOR COMPLETION BY EXAMINING DOCTOR OR NURSE

Further details of medical history and recreational activities

**KNOWN HYPERTENSIVE AND
DIABETIC ON ORAL MEDICATION**

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
175	88	28.7	160 90	86/min.	L A R A	DISTANT NEAR R L R L Uncorrected Corrected 6/6 6/6

N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A	
	✓	1. Urinalysis Sugar⁺, Protein⁺	✓		7. Audiogram
✓		2. Hb, Bloodcount, ESR			8. Lung Function
	✓	3. LFT, RFT, RBS			9. Chest X-Ray
		4. Drug Screen NA			10. ECG
✓		5. Lipids (40 years +)		✓	11. CVS risk for 40 yrs. & above 29.4%
✓		6. Sickie Cell test			12. HIV, Hepatitis screening

OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)

Referral to Cardidocan for TMT & Echo.

ASSESSMENT AND RECOMMENDATIONS:

☒ FIT ALL AREAS
 ☐ FIT WITH RESTRICTION
 ☐ TEMPORARY UNFIT
 ☐ UNFIT

with medications & follow up.

Date: 05/09/2021 Name (Block Capitals): Dr. / Nurse Signature:

REVIEW/CONSULTATION

Date: Name (Block Capitals): Dr. / Nurse Signature:

DR. SANATH BUDDHIKA PRIYADARSHAN
 GENERAL PRACTITIONER
 RUSAYL HEALTH CENTRE
 MOH LIC NO. 18343

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