مركز الرسيل الصحي
RHC **RUSAYL HEALTH CENTRE**
ISO 9001- 2015 Certified Co.

No. B 15619

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)

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

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Surname/ Forenames	Ali Saleem Rashid Al Hinai.
Nationality	Omani Turkoman
Mobile No 96115498 / Home/Leave Address: Bahla	Company Number: 10003 Reference Indicator:

Personal Details 43y / DoB - 01,09,1978 / ID - 8574748

A ☑ Male ☐ Female ☑ Married ☐ Single ☐ Separated /Divorced /Widow(er)

Home/Leave Address:

Relationship to employee ☐ Wife ☐ Son ☐ Daughter

No of Children:

Reason for Examination (tick as appropriate)

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

Employee only

B Present Job and Location: HDD

Next Job and Location: N. MV

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			
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		✓	DM / on follow up
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?		✓	As above
	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: 13/05/2022

Signature of Applicant:

RUSAYL HEALTH CE

مركز الرسيل الصحي
RUSAYL HEALTH CENTRE
ISO 9001- 2015 Certified Co.

No. B 15619

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.	NAD
✓		3. Teeth & Mouth	NAD
✓		4. Lungs & Chest	NAD
✓		5. Cardiovascular System	NAD
✓		6. Abdo. Viscera	NAD
✓		7. Hernial Orifices	NAD
✓		8. Anus & Rectum	NAD
✓		9. Genito-urinary	NAD
✓		10. Extremities	NAD
✓		11. Musculo-skeletal	NAD
✓		12. Skin & Varicose Vns.	NAD
✓		13. C.N.S.	NAD

HEIGHT cm	WEIGHT kg	BMI	B.P.	PULSE	HEARING	VISION
176	79	25	122/80	98 /mins.	L Normal, R Normal	Uncorrected / Corrected — DISTANT R/L 6/6; NEAR R/L 6/6

N	A		LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A	
	✓	1. Urinalysis	Normal on 08/06/2022	✓		7. Audiogram
✓		2. Hb, Bloodcount, ESR				8. Lung Function
	✓	3. LFT, RFT, RBS	FBS			9. Chest X-Ray
		4. Drug Screen	13/03/2022 08/06/2022	✓		10. ECG
	✓	5. Lipids (40 years +)	310 → 130	✓		11. CVS risk for 40 yrs. & above
✓		6. Sickle Cell test	TC - 210			12. HIV, Hepatitis screening

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

Advised to continue follow up for DM
Diet control, regular exercise

ASSESSMENT AND RECOMMENDATIONS:

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

with medications & monitoring

DR SAMATH BUDDHIKA PRIYADARSHAN
GENERAL PRACTITIONER
RUSAYL HEALTH CENTRE
MOH REG NO. 16042

Date: 08/06/2022 Name (Block Capitals): Dr. / Nurse Signature:

REVIEW/CONSULTATION

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

Fitness to Work Certificate for drivers

Employee Data			Date: 08/06/2022
Name: Ali Saleem Rashid Al Hinaai.			Department/Company : Truchoman
I.D. No: 8574948	Age: 43y		Occupation : HDD

Type of Medical Evaluation	Mark those applying √		
A5- HVD- Crane or forklift driving & all heavy vehicles	✓	A7- Professional driving-light vehicles	

Health Advisor Statement: The above named person has been examined according to the statements laid down in "Protocols and Guidance Notes on the Medical Evaluation of Fitness to Work". At this time his/her fitness to work status for the above tasks is as follows.

Fit with no restrictions with Medications & follow up. ✓			
Fit with following restriction(s)			
The employee is fit for above work but should avoid the following task(s)	***Temporary restriction***	***Permanent restriction***	
Work near moving machinery or sharp edges			
Operate Heavy motor vehicles, forklifts or heavy machinery			
Other (Specifiy)			
Temporary Unfit until			
Permanently Unfit			

DR. SANATH BUDDHIKA PRIYADARSHAN
GENERAL PRACTITIONER
RUSAYL HEALTH CENTRE
MOH LIC NO. 16042

Name of health advisor **Signature** 08/06/2022 **Date:**

Screening Quest. For Sleep Apnoea

Employee Data		Date: 13/03/2022
Name: Ali Saleem Rashid Al Hinaai.		Department/Company: Truckman
I. D No. 85749748	Tel #96115448	Occupation : HDD

This questionnaire will help identify if you have any health condition which may need a more detailed medical assessment as part of your fitness to work determination. If you have any queries please contact your local Health Services staff. All information provided on this form and during consultations remains strictly confidential. When further clinical evaluation is required following completion of a screening questionnaire, the details should be recorded on Q1 and E1 forms.

How likely are you to fall asleep in the following situations? (use 0 to 3 score as shown below)

0 Would never doze

1 Slight chance of dozing

2 Moderate chance of dozing

3 High chance of dozing

0	sitting and reading
0	watching TV
0	sitting inactive in a public place (e.g. theatre or meeting)
1	as a passenger in the car for an hour without a break
0	Lying down to rest in the afternoon when circumstances permit
0	Sitting a talking with someone
0	Sitting quietly after lunch without alcohol
0	In a car, while stopped for a few minutes in traffic
Total	01

If you score a total of 15 or more you should seek advice from medical personnel on site before continuing to drive or operate machinery in the workplace.

Declaration: I, Ali Saleem Rashid Al Hinaai. *(Print Name)* certify that to the best of my knowledge the above information supplied by me is true and **correct.**

Signature: _____ **Date:** 13/03/2022

DR SANATH BUDDHIKA PRIYADARSHANA
GENERAL PRACTITIONER
RUSAYL HEALTH CENTRE
MOH LIC NO. 16042