



# مركز الرسيل الصحي RUSAYL HEALTH CENTRE

ISO 9001 - 2015 Certified Co.

No. B 07927

## 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 SALIM SAIF (40 ym)		
Nationality	OMANI		
Company Number:	6117	Reference Indicator:	

Mobile No. 92224372	Home/Leave Address:
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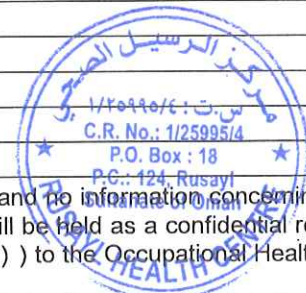
Personal Details		DOB - 15-07-1981	
A	<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced /Widow(er)	
Home/Leave Address: MUDABI OMAN		Relationship to employee	No of Children: 5
		<input type="checkbox"/> 1 Wife <input checked="" type="checkbox"/> 2 Son <input checked="" type="checkbox"/> 3 Daughter	

Reason for Examination (tick as appropriate)			
Periodic Medical Examination	<input checked="" type="checkbox"/>	Final / Retirement	<input type="checkbox"/>
Other Reason:		<input type="checkbox"/>	

Employee only	
B Present Job and Location:	Next Job and Location:
DRIVER HEAVY, TRUCK OMAN	NIMR
Are you a registered person with special needs?	Do you belong to any Medical Insurance Scheme?
<input type="checkbox"/>	<input type="checkbox"/>

**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		<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 your taken in the past?			<input checked="" type="checkbox"/>	
Do you smoke? If yes, what and how much each day?			<input checked="" type="checkbox"/>	
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: 05-07-2021

Signature of Applicant:



FOR COMPLETION BY EXAMINING DOCTOR OR NURSE

Further details of medical history and recreational activities

SAID SAHM SAIF (40 Yrs)

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			
163	59	22.21 Kg/m <sup>2</sup>	100 70 mmHg	72 /mins.	L N R N	DISTANT	NEAR		
						R L	R L		
						Uncorrected	Corrected	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 FBS				9. Chest X-Ray
		4. Drug Screen	- Not done	✓		10. ECG
✓		5. Lipids (40 years +)		✓		11. CVS risk for 40 yrs. & above ≥ 0.9%
✓		6. Sickie Cell test	- Negative			12. HIV, Hepatitis screening

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

No physical or mental abnormality found.

ASSESSMENT AND RECOMMENDATIONS:

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

05-07-2021 DR. MOHAMMAD HARUN AR RASHID

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

Signature:

REVIEW/CONSULTATION

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

Signature:

DR. MOHAMMAD HARUN AR RASHID  
MEDICAL OFFICER  
RUSAYL HEALTH CENTRE  
MOH LIC NO. 555