



# مركز الرسيل الصحي RUSAYL HEALTH CENTRE

ISO 9001- 2015 Certified Co.

No. B 07877

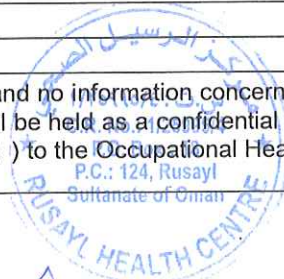
## ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



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

PLEASE COMPLETE YOUR PERSONAL  
DETAILS IN BLOCK CAPITALS

Surname/ Forenames		SAID ABDULLAH KHANIS (3944)	
Nationality		OMANI	
Mobile No.	95253718	Home/Leave Address:	
Company Number:		949	
Reference Indicator:			
Personal Details			
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: NEZWA OMAN		Relationship to employee	
		<input type="checkbox"/> Wife <input checked="" type="checkbox"/> Son <input type="checkbox"/> Daughter	
Reason for Examination (tick as appropriate)		No of Children: 2	
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? <input type="checkbox"/>		Do you belong to any Medical Insurance Scheme? <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		<input checked="" type="checkbox"/>	Ear, nose, eye or throat problems
2		<input checked="" type="checkbox"/>	Chest problems like asthma, bronchitis, other bad cough
3		<input checked="" type="checkbox"/>	Heart abnormality, chest pains
4		<input checked="" type="checkbox"/>	Abdominal pains, abnormal bowel motions
5		<input checked="" type="checkbox"/>	Urogenital problems (kidney disease, menstrual disorder)
6		<input checked="" type="checkbox"/>	Skin trouble or allergies
7		<input checked="" type="checkbox"/>	Epileptic fits, dizzy spells or migraine
8		<input checked="" type="checkbox"/>	History of mental illness, depression anxiety
9		<input checked="" type="checkbox"/>	Diabetes, thyroid disease
10		<input checked="" type="checkbox"/>	Blood disorder e.g. anaemia, blood cancer e.g. leukaemia
11		<input checked="" type="checkbox"/>	Any history of accidents or fractures
12		<input checked="" type="checkbox"/>	Have you had any serious allergies
13		<input checked="" type="checkbox"/>	Do any dependants have a significant ongoing illness?
14		<input checked="" type="checkbox"/>	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: 13-06-2021		Signature of Applicant:	



FOR COMPLETION BY EXAMINING DOCTOR OR NURSE

Further details of medical history and recreational activities

SAID ABDELAH KHAMIS (39 yrs)

N = Normal A = Abnormal (please describe)		PHYSICAL EXAMINATION
N	A	
✓		1. Eyes & Pupils
✓		2. E.N.T.
	✓	3. Teeth & Mouth <i>lost teeth-2</i>
✓		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 L N R N	VISION			
170	67	26.30 Kg/m <sup>2</sup>	130/80 mmHg	82/min.		DISTANT R L	NEAR 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 <i>FBS</i>			9. Chest X-Ray
		4. Drug Screen <i>- Not done</i>			10. ECG <i>- Not done</i>
✓		5. Lipids (40 years +)			11. CVS risk for 40 yrs. & above
✓		6. Sick Cell test <i>- Negative</i>			12. HIV, Hepatitis screening

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

• Lost teeth-2  
 • Overweight [BMI - 26.30 Kg/m<sup>2</sup>]  
 • No other physical or mental abnormality found

ASSESSMENT AND RECOMMENDATIONS:

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

13-06-2021 DR. MOHAMMAD HARUN AR RASHID

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

Signature:

REVIEW/CONSULTATION

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

Signature:

