



مركز الرسيل الصحي RUSAYL HEALTH CENTRE

ISO 9001 - 2015 Certified Co.

No. B 07077

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)

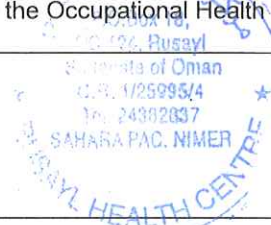


RUSAYL HEALTH CENTRE

ISO 9001 - 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Surname/ Forenames		Majid Ahmed Karom Al Bultashi	
Nationality		Omani	
Mobile No	Home/Leave Address:	Company Number:	Reference Indicator:
99516568	Sur	8068	Truckman
Personal Details			
A <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Married <input checked="" type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced /Widow(er)	
Home/Leave Address:		Relationship to employee	
		<input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	
		No of Children:	
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:	
Foreman		Muniri	
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?		<input checked="" type="checkbox"/>	
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?			
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:		Signature of Applicant:	
05/06/2021			



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	
<input checked="" type="checkbox"/>		1. Eyes & Pupils
<input checked="" type="checkbox"/>		2. E.N.T.
<input checked="" type="checkbox"/>		3. Teeth & Mouth
<input checked="" type="checkbox"/>		4. Lungs & Chest
<input checked="" type="checkbox"/>		5. Cardiovascular System
<input checked="" type="checkbox"/>		6. Abdo. Viscera
<input checked="" type="checkbox"/>		7. Hernial Orifices
<input checked="" type="checkbox"/>		8. Anus & Rectum
<input checked="" type="checkbox"/>		9. Genito-urinary
<input checked="" type="checkbox"/>		10. Extremities
<input checked="" type="checkbox"/>		11. Musculo-skeletal
<input checked="" type="checkbox"/>		12. Skin & Varicose Vns.
<input checked="" type="checkbox"/>		13. C.N.S.

HEIGHT cm	WEIGHT kg	BMI	B.P.	PULSE /mins.	HEARING L <i>Normal</i> R <i>Normal</i>	VISION DISTANT R <i>6/6</i> L <i>6/6</i> NEAR R <i>6/6</i> L <i>6/6</i>
<i>166</i>	<i>53</i>	<i>19.2</i>	<i>110/76</i>	<i>64</i>	Uncorrected Corrected	

N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A	
<input checked="" type="checkbox"/>		1. Urinalysis			7. Audiogram
<input checked="" type="checkbox"/>		2. Hb, Bloodcount, ESR			8. Lung Function
<input checked="" type="checkbox"/>		3. LFT, RFT, RBS			9. Chest X-Ray
<input checked="" type="checkbox"/>		4. Drug Screen			10. ECG
<input checked="" type="checkbox"/>		5. Lipids (40 years +)			11. CVS risk for 40 yrs. & above
<input checked="" type="checkbox"/>		6. Sickie Cell test			12. HIV, Hepatitis screening

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

NA D

ASSESSMENT AND RECOMMENDATIONS:

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

Date: *05/06/2021*

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

Signature: 

REVIEW/CONSULTATION

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

Signature:

