

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS



ریاضی سایل سیل
RUSAYL HEALTH CENTRE
SAHARA - PAC / RS - PAC

INITIAL EXAMINATION REPORT

Place of examination	Date	/ /
Bahja	11-11-18	
Home Telephone number 98197368		

If a dependant or fiancee entr employees name jere :-

Surname :

Forenames:

		Nationality Indian	Country of birth India	Religion Hindu
<input checked="" type="checkbox"/> Male	<input type="checkbox"/> Single	<input type="checkbox"/> Widow(er)	Relationship to employee	
<input type="checkbox"/> Female	<input checked="" type="checkbox"/> Married	<input type="checkbox"/> Divorced Separated	<input checked="" type="checkbox"/> Wife	<input checked="" type="checkbox"/> Son
			<input type="checkbox"/> Daughter	<input type="checkbox"/> Fiancee
			Number of Children 2	

Reason for examination Pre-employment
Poo mele'col, Pre-overseasJob :- Operator (Forklift),
Area:- Bahja

Name and address of family doctor	List your last 3 jobs
	(1)
	(2)
	(3)

Are you Registered Disabled Person? (UK)

 Do you belong to any Medical Insurance Scheme?

DO YOU HAVE OR HAVE YOU HAD :- (Tick "yes" or "No" column or put a (?) It unclain exclude minor ailmenis.)

	Y	N		Y	N		Y	N
1. Sirius rouble	<input checked="" type="checkbox"/>	<input type="checkbox"/>	22. Heart Disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>	42. Awarded benifites for Industrial injury/lilness	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Neck swellings/flands	<input checked="" type="checkbox"/>	<input type="checkbox"/>	23. Rheumatic Fever	<input checked="" type="checkbox"/>	<input type="checkbox"/>	43. Treated for a mental condition. eg . depression	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Difficulty in vision	<input checked="" type="checkbox"/>	<input type="checkbox"/>	24. Abnormal heartbeat	<input checked="" type="checkbox"/>	<input type="checkbox"/>	44. Treated for problem drinking or drug abuse	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Any ear discharge	<input checked="" type="checkbox"/>	<input type="checkbox"/>	25. High blood pressure	<input checked="" type="checkbox"/>	<input type="checkbox"/>	45. Exposed to toxic substance or noise	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Asthma/bronchitis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	26. Stroke	<input checked="" type="checkbox"/>	<input type="checkbox"/>	FOR WOMEN ONLY		
6. Hayfever/other allergy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	27. Serious chest pain	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Have you ever had:-		
7. Any skin trouble	<input checked="" type="checkbox"/>	<input type="checkbox"/>	28. Any blood disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>	46. An abnormal smear		
8. Tuberculosis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	29. Kidney disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>	47. Any gynaecological treatment		
9. Shortness of breath	<input checked="" type="checkbox"/>	<input type="checkbox"/>	30. Painful passage of urine	<input checked="" type="checkbox"/>	<input type="checkbox"/>	48. Are you pregnant?		
10. Coughed/vomited blood	<input checked="" type="checkbox"/>	<input type="checkbox"/>	31. Blood in urine	<input checked="" type="checkbox"/>	<input type="checkbox"/>	49. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE ?		
11. Severe abdominal pain	<input checked="" type="checkbox"/>	<input type="checkbox"/>	32. Diabetes	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
12. Stomach ulcer	<input checked="" type="checkbox"/>	<input type="checkbox"/>	33. Headaches /migraine	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
13. Recurrent indigestion	<input checked="" type="checkbox"/>	<input type="checkbox"/>	34. Dizziness/tainting	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
14. Jaundice or hepatitis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	35. Epilepsy	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
15. Gall bladder disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>	36. Joints/spinal trouble	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
16. Marked change in bowel habits	<input checked="" type="checkbox"/>	<input type="checkbox"/>	37. Surgical operation	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
17. Blood in stools (motions)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	38. Serious accident /fracture	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
18. Marked change in weight	<input checked="" type="checkbox"/>	<input type="checkbox"/>	39. Tropical disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
19. Varicose veins	<input checked="" type="checkbox"/>	<input type="checkbox"/>	40. Fear of heights	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
20. Lump in breast/armpit	<input checked="" type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER BEEN:-					
21. Cancer	<input checked="" type="checkbox"/>	<input type="checkbox"/>	41. Rejected for employment or insurance for medical reasons	<input checked="" type="checkbox"/>	<input type="checkbox"/>			

How much tabacco each day ?

N/A

Average daily alcohol consuption

Social drinker

Family history	Diabetes <input checked="" type="checkbox"/>	Tuberculosis <input checked="" type="checkbox"/>	Epilepsy <input checked="" type="checkbox"/>	Asthma <input checked="" type="checkbox"/>	Eczema <input checked="" type="checkbox"/>	Cancer <input checked="" type="checkbox"/>	Blood disease <input checked="" type="checkbox"/>
	Heart disease <input type="checkbox"/>	High blood pressure <input checked="" type="checkbox"/>		Stroke <input checked="" type="checkbox"/>			

PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT :-

I declare these statements to be true to the best of my knowledge and belief and I agree that the result of this medical in general terms may be revealed to the company if required, and the details sent to my own doctor if this is considered necessary by the examining medical officer.

Date

11-11-18

Signature of applicant

L. Ramesh

FOR COMPLETION BY EXAMINING DOCTOR OR SISTER
FURTHER DETAILS OF MEDICAL HISTORY AND RECREATIONAL ACTIVITIES

N - Normal A - Abnormal Please Describe		PHYSICAL EXAMINATION								
N	A	<ul style="list-style-type: none"> 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. Muscula-skeletal 12. Skin & Varicose Vns. 13. C.N.S. 14. Breasts 15. 								
HEIGHT cm	WEIGHT kg	B.P. 138/88 mmHg	HEARING L R	HEARING L R	VISION: Uncorrected Corrected	DISTANT R L	NEAR R L	COLOUR VISION	BLOOD GROUP	
160 cm	81 kg									
N	A	LABORATORY AND SPECIAL INVESTIGATIONS					N	A		
		<ul style="list-style-type: none"> 1. Urimalysis 2. Hb Bloodcount ESR 3. Sarum Profile 4. Stool 5. E.C.G. <p>* Dyslipidemia</p>								

OTHER FINDINGS (physique, scars, disabilities, mental stability etc.)

* Bmi : Over weight

Adv:

- Avoid extra calories and fatty foods
- Do regular physical exercise

ASSESSMENT

FIT ALL AREAS FIT HOME SERVICES ONLY UNFIT/UNSUITABLE MAY BE REASSESSSED

DR. MOHAMMAD MARUF FERDOUS

MEDICAL OFFICER
RUSAYL HEALTH CENTRE

Date 11-11-18

Signature

Doctor / Sister

REVIEW/CONSULTATION

Date

Signature

Name (Block Capitals)

Doctor / Sister

