



مركز الرسيل الصحي RUSAYL HEALTH CENTRE

ISO 9001 - 2015 Certified Co.

No. B 09696

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)

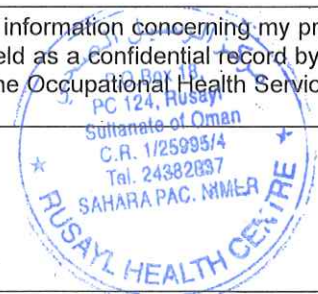


RUSAYL HEALTH CENTRE

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PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Surname/ Forenames: Gurpreet Singh Kashmir Singh		Nationality: Indian	
Mobile No. 97335083	Home/Leave Address: 44y 1 DUB - 20,02, 1977	Company Number: 1352	Reference Indicator: Truckman
Personal Details			
A ☒ Male ☐ Female		☒ Married ☐ Single ☐ Separated /Divorced /Widow(er)	
Home/Leave Address: 44y 1 DUB - 20,02, 1977		Relationship to employee ☐ Wife ☐ Son ☐ Daughter	
		No of Children: 02	
Reason for Examination (tick as appropriate)			
Periodic Medical Examination ☒ Final / Retirement ☐ Other Reason: ☐			
Employee only			
B Present Job and Location: ADD		Next Job and Location: NIN	
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
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?			
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: 05/10/2021		Signature of Applicant: ase	





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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
		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
175	73	23.8	112/82	60/min.	L Normal R Normal	DISTANT R 6/6 L 6/6 NEAR R 6/6 L 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			9. Chest X-Ray
		4. Drug Screen			10. ECG
		5. Lipids (40 years +)			11. CVS risk for 40 yrs. & above
		6. Sickle Cell test			12. HIV, Hepatitis screening

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

Azise 2 on low fat diet.
regular exercise

ASSESSMENT AND RECOMMENDATIONS:

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

Date: 05/10/2021

Name (Block Capitals): Dr. / Nurse

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

Signature:

REVIEW/CONSULTATION

Date:

Name (Block Capitals): Dr. / Nurse

Signature:

