

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE  
ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL  
DETAILS IN BLOCK CAPITALS

Surname/  
Forenames Ahmed Zaydi Khalifa  
Nationality Al Naqami  
Omani

Mobile No 97733166 Home/Leave Address: Sunwai  
Dob 30/09/1991 Company Number: 10233 Reference Indicator: 11972346

Personal Details 30/09/1991  
A  Male  Female  Married  Single  Separated /Divorced /Widow(er)

Home/Leave Address:  Wife  Son  Daughter No of Children: 01

Reason for Examination (tick as appropriate)

Periodic Medical Examination  Final / Retirement  Other Reason:

Employee only

B Present Job and Location: Helper Next Job and Location: NIMR

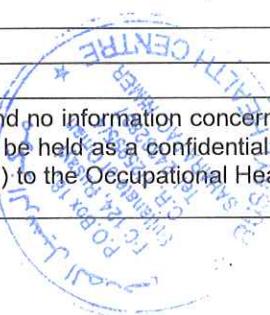
Are you a registered person with special needs?  Do you belong to any Medical Insurance Scheme?

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 you 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.

09/05/2021   
Date: Signature of Applicant: 

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.	(N/A)									
		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 156		WEIGHT kg 69	BMI 28.4	B.P. 122 82	PULSE 79/mins.	HEARING L Normal R Normal Uncorrected Corrected	DISTANT R L		VISION NEAR R L			
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.)**

## A2vise2 on original of auction.

## ASSESSMENT AND RECOMMENDATIONS:

FIT ALL AREAS     FIT WITH RESTRICTION     TEMPORARY UNFIT     UNFIT

Date: \_\_\_\_\_ Name: \_\_\_\_\_

## REVIEW/CONSULTATION

Date: \_\_\_\_\_ Name ( ) \_\_\_\_\_

Date: \_\_\_\_\_ Name (Block Capitals): Dr. / Nurse \_\_\_\_\_ Signature: 

Date: \_\_\_\_\_ Name (Block Capitals): Dr. / Nurse \_\_\_\_\_ Signature: 