

8144

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS



الصحيه الرسالي
RUSAYL HEALTH CENTRE
NIMR, FAHUD, QARNALAY, BHAJA, SAHRWAL, MARWAL

INITIAL EXAMINATION REPORT

Place of examination **MOKMUL** Date **14/11/18**

Surname **ALI MUSA JAMIL AL BREIKI**
Forenames
Address **Truck Oman** C.U. **15308614**
Home Telephone number **96776063**

If a dependant or fiancee entr employees name jere :-

Surname :

Forenames:

		Nationality	Country of birth	Religion	Number of Children
<input checked="" type="checkbox"/> Male	<input type="checkbox"/> Single	<input type="checkbox"/> Widow(er)	<input type="checkbox"/> Wife	<input type="checkbox"/> Son	<input type="checkbox"/> Daughter
<input type="checkbox"/> Female	<input checked="" type="checkbox"/> Married	<input type="checkbox"/> Divorced Separated	<input type="checkbox"/> Fiancee		3

Reason for examination Pre-employment Job :-
 Pre-overseas Area:-

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

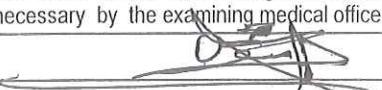
Are you Registered Disabled Person? (UK) Do you belong to any Medical Insurance Scheme?

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

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

How much tabacco each day ?	No	Average daily alcohol consuption	No
Family history	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Epilepsy
	<input type="checkbox"/> Heart disease	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Asthma
			<input type="checkbox"/> Eczerna
			<input type="checkbox"/> Cancer
			<input type="checkbox"/> Blood disease

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 **14/11/18** Signature of applicant 



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									
		1. Eyes & Pupils 2. E.N.T. 3. Teeth & Mouth 4. Lungs & Chest 5. Cardiovascular System 6. Abdo. Viscera 7. Hermal Orifices 8. Anus & Rectum 9. Genito - urinary 10. Extremities 11. Muscula-skeletal 12. Skin & Varicose Vns. 13. C.N.S. 14. Breasts 15.								
175	87	110/80	L R	L R	VISION: Uncorrected Corrected	DISTANT R 6 L 6	NEAR R 6 L 6	COLOUR VISION Clay	BLOOD GROUP	
N A		LABORATORY AND SPECIAL INVESTIGATIONS					N	A		
		Bm 8 = 29.06							1. Urimalysis 2. Hb Bloodcount ESR 3. Sarum Profile 4. Stool 5. E.C.G. 6. Audiogram 7. Lung Function 8. Chest X-Ray 9. Drug Screen 10. CR Screen	
OTHER FINDINGS (physique, scars, disabilities, mental stability etc.)										

ASSESSMENT

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

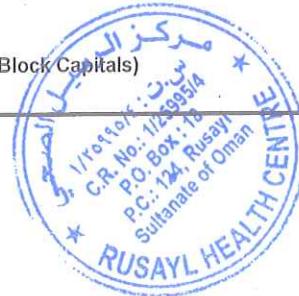
Date 14/11/09



Name (Block Capitals)

Doctor / Sister

REVIEW/CONSULTATION



Date

Signature

Name (Block Capitals)

Doctor / Sister