

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE

ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Surname/Forenames		mohammed Hamood A ( Hikman )	
Nationality		OMAN	
Company Number:		10273	Reference Indicator:

Mobile No 94764417

Home/Leave Address: Barka

Personal Details

26y 1 DOB - 12/11/1995 / ID - 18925005

A  Male  Female

Married  Single  Separated /Divorced /Widow(er)

Home/Leave Address:

Wife  Son  Daughter

No of Children:

Reason for Examination (tick as appropriate)

Periodic Medical Examination

Final / Retirement

Other Reason:

Employee only

B Present Job and Location:

Next Job and Location:

Helper

Nimr / Munaa

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?		<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 you taken in the past?		<input checked="" type="checkbox"/>	
Do you smoke? If yes, what and how much each day?		<input checked="" type="checkbox"/>	
Do you drink alcohol? If yes, what is your average weekly intake?		<input checked="" type="checkbox"/>	
Have you ever taken elicited/recreational drugs?		<input checked="" type="checkbox"/>	
Are you doing regular sports or physical activities?		<input checked="" type="checkbox"/>	

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.

06/07/2021

Signature of Applicant:



Date:

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 R	Normal Normal Uncorrected Corrected	DISTANT R L	VISION R L
161	117	45	124/84	68			6/6	6/6

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. Sickle Cell test		12. HIV, Hepatitis screening

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

② Advise on weight reduction  
strict diet control, regular exercise

ASSESSMENT AND RECOMMENDATIONS:

FIT ALL AREAS  FIT WITH RESTRICTION  TEMPORARY UNFIT  UNFIT

06/07/2021

Date:

Name (Block Capitals): Dr. / Nurse

Signature:



REVIEW/CONSULTATION

Date:

Name (Block Capitals): Dr. / Nurse

Signature: