

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE
ISO 9001- 2015 Certified Co.

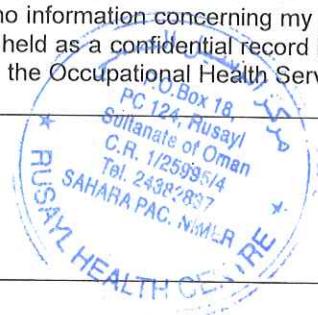
PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Mobile No: 92232798	Home/Leave Address: Nakhal	Surname/Forenames: Ahmed, Mohammed, Salam, Ali, Riyam	
		Nationality: Omani	
		Company Number: 970	
		Reference Indicator: Trukhwan	
Personal Details: 40y DOB - 01/01/1982 ID - 9250298			
A <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced /Widow(er)		
Home/Leave Address:	Relationship to employee: <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	No of Children:	
Reason for Examination (tick as appropriate)			
Periodic Medical Examination <input checked="" type="checkbox"/> Final / Retirement <input type="checkbox"/> Other Reason: <input type="checkbox"/>			
Employee only			
B Present Job and Location: IHDS	Next Job and Location: NIMN		
Are you a registered person with special needs? <input type="checkbox"/>	Do you belong to any Medical Insurance Scheme? <input type="checkbox"/>		
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	<input checked="" type="checkbox"/>		
2 Chest problems like asthma, bronchitis, other bad cough	<input type="checkbox"/>		
3 Heart abnormality, chest pains	<input type="checkbox"/>		
4 Abdominal pains, abnormal bowel motions	<input type="checkbox"/>		
5 Urogenital problems (kidney disease, menstrual disorder)	<input type="checkbox"/>		
6 Skin trouble or allergies	<input type="checkbox"/>		
7 Epileptic fits, dizzy spells or migraine	<input type="checkbox"/>		
8 History of mental illness, depression anxiety	<input type="checkbox"/>		
9 Diabetes, thyroid disease	<input type="checkbox"/>		
10 Blood disorder e.g. anaemia, blood cancer e.g. leukaemia	<input type="checkbox"/>		
11 Any history of accidents or fractures	<input type="checkbox"/>		
12 Have you had any serious allergies	<input type="checkbox"/>		
13 Do any dependants have a significant ongoing illness?	<input type="checkbox"/>		
14 Any family history of cancers	<input type="checkbox"/>		
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.

13/03/2022

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.											
	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 mins.	HEARING L R	HEARING R Uncorrected Corrected	DISTANT R L	VISION R L	
169	83	29	116/78	86	N/Normal N/Normal	Uncorrected Corrected	6/6	6/6	
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS							
✓		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.)

ASSESSMENT AND RECOMMENDATIONS:

FIT ALL AREAS FIT WITH RESTRICTION TEMPORARY UNFIT UNFIT

13/03/2022

DR. SANATH BUDDHika PRIYadarshan
GENERAL PRACTITIONER
RUSAYL HEALTH CENTRE

Date:

Name (Block Capitals): Dr. / Nurse


Signature:

REVIEW/CONSULTATION

Date:

Name (Block Capitals): Dr. / Nurse

Signature:

