

03
25/10/91
ANL-89078772



مکالمہ سیل المیہ
RUSAYL HEALTH CENTRE
NIER, FAHUD, QARNALAM, BHAJA, SAIHRWAL, MARWAL

INITIAL EXAMINATION REPORT

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

1366

Surname SINGH	
Forenames KESAR	
Address STRNCM OMAN	
Place of examination RS PAC CLINIC BAHJA	
Date 27/04/19	
Home Telephone number 9653 8294	

If a dependant or fiancee entr employees name jere :-

Surname :

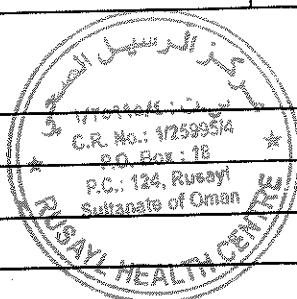
Forenames:

Nationality INDIAN		Country of birth INDIA		Religion SIKHISM	
<input checked="" type="checkbox"/> Male	<input type="checkbox"/> Single	<input checked="" type="checkbox"/> Widow(er)	<input checked="" 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	Number of Children 3	

Reason for examination Pre-employment **Job :- DREVER (HEAVY)**
 Pre-overseas **Area:- BAHJA**

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 uncertain exclude minor ailmenis.)

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

How much tabacco each day? **Non-smoker**

Average daily alcohol consuption

Family history	<input checked="" type="checkbox"/> Diabetes	<input checked="" type="checkbox"/> Tuberculosis	<input checked="" type="checkbox"/> Epilepsy	<input checked="" type="checkbox"/> Asthma	<input checked="" type="checkbox"/> Eczema
Heart disease	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> High blood pressure	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> Stroke	<input checked="" type="checkbox"/> Cancer
					<input checked="" 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 **27/04/19**

Signature of applicant

See SW

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	BME-26.6 kg/m ² HR-84b/min								
✓	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. Muscula-skeletal									
✓	12. Skin & Varicose Vns.									
✓	13. C.N.S.									
✓	14. Breasts									
	15.									
HEIGHT cm	WEIGHT kg	B.P.	HEARING L R	HEARING L R	VISION: Uncorrected Corrected	DISTANT R N/N	NEAR R N/N	COLOUR VISION	BLOOD GROUP	
163	70.7	168/100								

N	A	LABORATORY AND SPECIAL INVESTIGATIONS									N	A
✓	1. Urinalysis											6. Audiogram
✓	2. Hb Bloodcount ESR											7. Lung Function
✓	3. Serum Profile											8. Chest X-Ray
✓	4. Stool											9. Drug Screen
✓	5. E.C.G.											10. CR Screen

OTHER FINDINGS (physique, scars, disabilities, mental stability etc.)

BME-26.6 kg/m²

Adv

1. Check BP regularly to exclude HTN.

11
12

ASSESSMENT

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

Date 28.04.19

Signature

DR. HASAN MAHBUB KHAN BAYZID
 Name (Block Capitals)
RUSAYI HEALTH CENTRE
 MOH LIC NO. 15691

Doctor / Sister

REVIEW/CONSULTATION

Date

Signature

Name (Block Capitals)

Doctor / Sister