

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE
ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Mobile No. 99789692		Home/Leave Address:	Surname/ Forenames SULAIMAN 'ABDULLAH SAMI AL SHERAILI																																																																																					
			Nationality 46 / M / Omani																																																																																					
			Company Number: # 882	Reference Indicator:																																																																																				
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<p>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.</p> <p>Please answer the following questions and tick 'N' (no) or 'Y' (yes) in the column. If 'Y' Please describe</p> <table border="1"> <thead> <tr> <th></th> <th>N</th> <th>Y</th> <th>Description</th> </tr> </thead> <tbody> <tr> <td>Have you, since your last medical been treated by your family doctor or specialist for significant (major) ailments?</td> <td></td> <td></td> <td></td> </tr> <tr> <td>1 Ear, nose, eye or throat problems</td> <td></td> <td><input checked="" type="checkbox"/></td> <td></td> </tr> <tr> <td>2 Chest problems like asthma, bronchitis, other bad cough</td> <td></td> <td><input checked="" type="checkbox"/></td> <td></td> </tr> <tr> <td>3 Heart abnormality, chest pains</td> <td></td> <td><input checked="" type="checkbox"/></td> <td></td> </tr> <tr> <td>4 Abdominal pains, abnormal bowel motions</td> <td></td> <td><input checked="" type="checkbox"/></td> <td></td> </tr> <tr> <td>5 Urogenital problems (kidney disease, menstrual disorder)</td> <td></td> <td><input checked="" type="checkbox"/></td> <td></td> </tr> <tr> <td>6 Skin trouble or allergies</td> <td></td> <td><input checked="" type="checkbox"/></td> <td></td> </tr> <tr> <td>7 Epileptic fits, dizzy spells or migraine</td> <td></td> <td><input checked="" type="checkbox"/></td> <td></td> </tr> <tr> <td>8 History of mental illness, depression anxiety</td> <td></td> <td><input checked="" type="checkbox"/></td> <td></td> </tr> <tr> <td>9 Diabetes, thyroid disease</td> <td></td> <td><input checked="" type="checkbox"/></td> <td></td> </tr> <tr> <td>10 Blood disorder e.g. anaemia, blood cancer e.g. leukaemia</td> <td></td> <td><input checked="" type="checkbox"/></td> <td></td> </tr> <tr> <td>11 Any history of accidents or fractures</td> <td></td> <td><input checked="" type="checkbox"/></td> <td></td> </tr> <tr> <td>12 Have you had any serious allergies</td> <td></td> <td><input checked="" type="checkbox"/></td> <td></td> </tr> <tr> <td>13 Do any dependants have a significant ongoing illness?</td> <td></td> <td><input checked="" type="checkbox"/></td> <td></td> </tr> <tr> <td>14 Any family history of cancers</td> <td></td> <td><input checked="" type="checkbox"/></td> <td></td> </tr> <tr> <td>Do you take any regular medicines, or have you taken in the past?</td> <td></td> <td><input checked="" type="checkbox"/></td> <td></td> </tr> <tr> <td>Do you smoke? If yes, what and how much each day?</td> <td></td> <td><input checked="" type="checkbox"/></td> <td>occasional</td> </tr> <tr> <td>Do you drink alcohol? If yes, what is your average weekly intake?</td> <td></td> <td><input checked="" type="checkbox"/></td> <td></td> </tr> <tr> <td>Have you ever taken elicited/recreational drugs?</td> <td></td> <td><input checked="" type="checkbox"/></td> <td></td> </tr> <tr> <td>Are you doing regular sports or physical activities?</td> <td></td> <td><input checked="" type="checkbox"/></td> <td></td> </tr> </tbody> </table>						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 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"/>	occasional	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"/>	
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<p>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.</p>																																																																																								
Date: 16 July 2023	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. 140 90 6 130 80	PULSE /mins. 71	HEARING L (N) R (N)	VISION	
						DISTANT R L	NEAR R L
168	70	24.8				Uncorrected 6/6	Corrected 6/6 6/6 6/6 6/6

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 9.42
✓		6. Sickle Cell test		12. HIV, Hepatitis screening

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

As Dyslipidemia, mild

ASSESSMENT AND RECOMMENDATIONS:

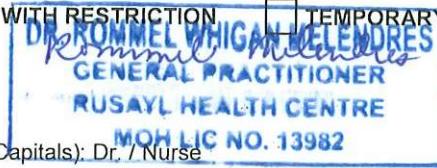
FIT ALL AREAS

FIT WITH RESTRICTION

TEMPORARY UNFIT

UNFIT

16 July 2023



Date:

Name (Block Capitals): Dr. / Nurse

Signature:

REVIEW/CONSULTATION

p> Low-fat diet, exercise; Repeat lipid profile after 3-6 months
Practice healthy lifestyle

Date: 16 July 2023 Name (Block Capitals): Dr. / Nurse

Signature:

