

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE  
ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL  
DETAILS IN BLOCK CAPITALS

<p>Mobile No: 79361810</p> <p>Personal Details 44y 1 DSB</p>		<p>Home/Leave Address: Suwair</p> <p>Surname/Forenames Jamil Abdallah</p>																																																																																				
<p>A <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female</p>		<p>Nationality Nationality</p>																																																																																				
<p>Relationship to employee</p> <p>Home/Leave Address:</p>		<p>Company Number: 730</p> <p>Reference Indicator: Oman, Trukouan</p>																																																																																				
<p>Reason for Examination (tick as appropriate)</p> <p>Periodic Medical Examination <input checked="" type="checkbox"/> Final / Retirement <input type="checkbox"/> Other Reason: <input type="checkbox"/></p>																																																																																						
<p>Employee only</p> <p>B Present Job and Location: Supervisor Next Job and Location: NIMR</p>																																																																																						
<p>Are you a registered person with special needs? <input type="checkbox"/> Do you belong to any Medical Insurance Scheme? <input type="checkbox"/></p>																																																																																						
<p><b>Previous Medical History:</b> 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><input checked="" type="checkbox"/></td> <td></td> <td></td> </tr> <tr> <td>1 Ear, nose, eye or throat problems</td> <td><input checked="" type="checkbox"/></td> <td></td> <td></td> </tr> <tr> <td>2 Chest problems like asthma, bronchitis, other bad cough</td> <td><input checked="" type="checkbox"/></td> <td></td> <td></td> </tr> <tr> <td>3 Heart abnormality, chest pains</td> <td><input checked="" type="checkbox"/></td> <td></td> <td></td> </tr> <tr> <td>4 Abdominal pains, abnormal bowel motions</td> <td><input checked="" type="checkbox"/></td> <td></td> <td></td> </tr> <tr> <td>5 Urogenital problems (kidney disease, menstrual disorder)</td> <td><input checked="" type="checkbox"/></td> <td></td> <td></td> </tr> <tr> <td>6 Skin trouble or allergies</td> <td><input checked="" type="checkbox"/></td> <td></td> <td></td> </tr> <tr> <td>7 Epileptic fits, dizzy spells or migraine</td> <td><input checked="" type="checkbox"/></td> <td></td> <td></td> </tr> <tr> <td>8 History of mental illness, depression anxiety</td> <td><input checked="" type="checkbox"/></td> <td></td> <td></td> </tr> <tr> <td>9 Diabetes, thyroid disease</td> <td><input checked="" type="checkbox"/></td> <td></td> <td></td> </tr> <tr> <td>10 Blood disorder e.g. anaemia, blood cancer e.g. leukaemia</td> <td><input checked="" type="checkbox"/></td> <td></td> <td></td> </tr> <tr> <td>11 Any history of accidents or fractures</td> <td><input checked="" type="checkbox"/></td> <td></td> <td></td> </tr> <tr> <td>12 <b>Have you had any serious allergies</b></td> <td><input checked="" type="checkbox"/></td> <td></td> <td></td> </tr> <tr> <td>13 Do any dependants have a significant ongoing illness?</td> <td><input checked="" type="checkbox"/></td> <td></td> <td></td> </tr> <tr> <td>14 Any family history of cancers</td> <td><input checked="" type="checkbox"/></td> <td></td> <td></td> </tr> <tr> <td colspan="4">Do you take any regular medicines, or have you taken in the past?</td> </tr> <tr> <td colspan="4">Do you smoke? If yes, what and how much each day?</td> </tr> <tr> <td colspan="4">Do you drink alcohol? If yes, what is your average weekly intake?</td> </tr> <tr> <td colspan="4">Have you ever taken elicited/recreational drugs?</td> </tr> <tr> <td colspan="4">Are you doing regular sports or physical activities?</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?	<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 <b>Have you had any serious allergies</b>	<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?				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?			
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<p><b>STATEMENT:</b> 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>																																																																																						
<p>Date: 27/06/2021</p>		<p>Signature of Applicant:</p>																																																																																				
<p>P.O.Box 18, PC 124 Ruisayl Sultanate of Oman C.R. 1/25995/4 Tel. 24382837 SAHARA PAC. NIMR</p>																																																																																						

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	NAD					
<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 182	WEIGHT kg 80	BMI 24.2	B.P. 129 86	PULSE 67 /mins.	HEARING L Normal R Normal Uncorrected Corrected	DISTANT R L 6/ 6/6	VISION R L 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.)								
NAD								
ASSESSMENT AND RECOMMENDATIONS:								
<input checked="" type="checkbox"/> FIT ALL AREAS		<input type="checkbox"/> FIT WITH RESTRICTION		<input type="checkbox"/> TEMPORARY UNFIT		<input type="checkbox"/> UNFIT		
27/06/2021		Date:		Name (Block Capitals): Dr. / Nurse		Signature:		
REVIEW/CONSULTATION								
Date:		Name (Block Capitals): Dr. / Nurse		Signature:				

DR. SANATH BUDDHIKA PRIYADARSHAN  
GENERAL PRACTITIONER  
RUSAYL HEALTH CENTRE  
MOH LIC NO. 16042