

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE

ISO 9001-2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Surname/Forenames		Khalid Ali Itumoid	
Nationality		Al Jaber	
		Oman	

Mobile No	99796192	Home/Leave Address:	sunai, n	Company Number:	10025	Reference Indicator:	Truckoman
-----------	----------	---------------------	----------	-----------------	-------	----------------------	-----------

Personal Details

959 / DOB-18/04/1977 / ID-9991051

A <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced /Widow(er)
----------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------

Home/Leave Address:	<input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> 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:	Nimr
11 DD		
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

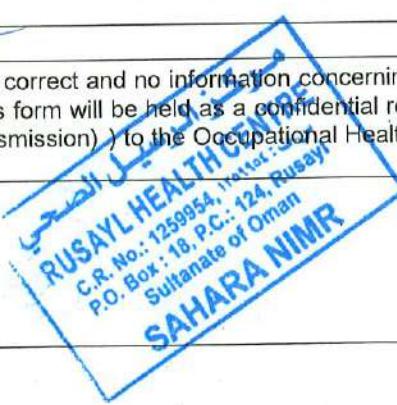
	N	Y	Description
Have you, since your last medical been treated by your family doctor or specialist for significant (major) ailments?			
1 Ear, nose, eye or throat problems			
2 Chest problems like asthma, bronchitis, other bad cough			
3 Heart abnormality, chest pains			
4 Abdominal pains, abnormal bowel motions			
5 Urogenital problems (kidney disease, menstrual disorder)			
6 Skin trouble or allergies			
7 Epileptic fits, dizzy spells or migraine			
8 History of mental illness, depression anxiety			
9 Diabetes, thyroid disease			
10 Blood disorder e.g. anaemia, blood cancer e.g. leukaemia			
11 Any history of accidents or fractures			
12 Have you had any serious allergies			
13 Do any dependants have a significant ongoing illness?			
14 Any family history of cancers			
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.

Date:

02/02/2023

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.	PULSE mins.	HEARING L R	VISION DISTANT R L	VISION NEAR R L
195	100	33	126/86	75	N/N Uncorrected N/N Corrected	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
		6. Sickle Cell test		12. HIV, Hepatitis screening

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

A advise on戒烟和戒酒,  
禁烟禁酒, 健康饮食, 避免过度劳累, 适当运动.

ASSESSMENT AND RECOMMENDATIONS:

FIT ALL AREAS  FIT WITH RESTRICTION  TEMPORARY UNFIT  UNFIT

DR. SANATH BUDDHIKA PRIYADARSHAN

GENERAL PRACTITIONER  
RUSAYL HEALTH CENTRE

02/02/2023

Date: Name (Block Capitals): Dr. / Nurse

Report  
PCP / LFT  
after 03 months.

REVIEW/CONSULTATION

Date: Name (Block Capitals): Dr. / Nurse

