



مركز الرسيل الصحي RUSAYL HEALTH CENTRE

ISO 9001 - 2015 Certified Co.

No. B 12777

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 / Ahmad**
Al Jahwari

Nationality

OMAN

Mobile No:

99796192

Home/Leave Address:

Suwayh

Company Number:

10025

Reference Indicator:

Truckman

Personal Details

45y

DOB - 18, 04, 1977

ID - 9491051

A ☒ Male ☐ Female

☒ Married ☐ Single ☐ Separated /Divorced /Widow(er)

Home/Leave Address:

Relationship to employee

☐ Wife ☐ Son ☐ Daughter

No of Children:

Reason for Examination (tick as appropriate)

Periodic Medical Examination ☒

Final / Retirement ☐

Other Reason: ☐

Employee only

B Present Job and Location:

14 DD

Next Job and Location:

NIMR

Are you a registered person with special needs? ☐

Do you belong to any Medical Insurance Scheme? ☐

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 your 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?			

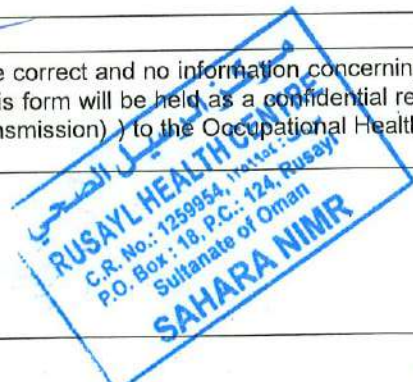
STATEMENT: I have read the above questions and the above answers are correct and no information concerning my present or past state of health has been withheld. I understand and agree that this form will be held as a confidential record by PDO Medical Department, and may be copied (by paper or secure 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:

[Signature]



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.
175	100	33	126/80
PULSE	HEARING	VISION	
75/min.	L Normal R Normal	DISTANT NEAR R L R L Uncorrected Corrected	
		16 6/8	
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. Sick Cell test	12. HIV, Hepatitis screening
OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.) Advised on weight reduction. Low fat diet, penicillin Overall, stable for 6m.			
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			
Date: 02/02/2023 Name (Block Capitals): Dr. / Nurse Signature: 			
REVIEW/CONSULTATION Date: Name (Block Capitals): Dr. / Nurse Signature: 