

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)

RUSAYL HEALTH CENTRE
PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Surname/ Forenames:	AHMED KHAMIS SHAMIS AL-MAANI,39YRS
Nationality:	OMAN

Mobile No. 95931055	Home/Leave Address: BAHLA- NIZWA	Company Number: 930	Reference Indicator: TRUC <i>K O M A N</i>
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Personal Details

A <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced
Home/Leave Address: BAHLA- NIZWA	Relationship To Employee <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter

No Of Children:

Reason For Examination (tick As Appropriate)

Periodic Medical Examination <input type="checkbox"/> Initial <input checked="" type="checkbox"/> Periodic
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Employee Only

B Present Job And Location: NIMR-HSE SAFTY	Next Job And Location: NIMR
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?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Ear, Nose, Eye Or Throat Problems	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Chest Problems Like Asthma, Bronchitis, Other Bad Cough	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Heart Abnormality, Chest Pains	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Abdominal Pains, Abnormal Bowel Motions	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Urogenital Problems (kidney Disease, Menstrual Disorder)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Skin Trouble Or Allergies	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Epileptic Fits, Dizzy Spells Or Migraine	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
History Of Mental Illness, Depression Anxiety	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Diabetes, Thyroid Disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>	DM ON MEDICATIONS
Blood Disorder E.G. Anaemia, Blood Cancer E.G. Leukaemia	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Any History Of Accidents Or Fractures	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Have You Had Any Serious Allergies	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Any Family History Of Cancers	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Do You Take Any Regular Medicines, Or Have You Taken In The Past	<input type="checkbox"/>	<input checked="" type="checkbox"/>	DM
Do You Smoke? If Yes, What And How Much Each Day?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Do You Drink Alcohol? If Yes, What Is Your Average Weekly Intake?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Have You Ever Taken Elicted/recreational Drugs?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Are You Doing Regular Sports Or Physical Activities?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	

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: *30/10/23* Signature : *867*

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"/>	<input type="checkbox"/>	Eyes Pupils							
<input checked="" type="checkbox"/>	<input type="checkbox"/>	ENT							
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Teeth Mouth							
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Lungs Chest							
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Cardiovascular System							
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Abdo Viscera							
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Hernial Orifices							
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Anus Rectum							
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Genito Urinary							
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Extremities							
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Musculo Skeletal							
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Skin Varicose Vns							
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Cns							
HEIGHT 166 Cm	WEIGHT 88 Kg	BMI 32	B.P 110/76	PULSE 69/mins	HEARING L: NORMAL R: NORMAL	VISION: RIGHT 6/6 , LEFT 6/6		Colour Vision: N	Blood Group: N/A

N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS				N	A	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	1.Urinalysis				<input type="checkbox"/>	<input type="checkbox"/>	7.Audiogram
<input checked="" type="checkbox"/>	<input type="checkbox"/>	2 Hb, Bloodcount, ESR				<input type="checkbox"/>	<input type="checkbox"/>	8. Lung Function
<input checked="" type="checkbox"/>	<input type="checkbox"/>	3 LFT, RFT, RBS/FBS				<input type="checkbox"/>	<input type="checkbox"/>	9. Chest X-Ray
<input type="checkbox"/>	<input type="checkbox"/>	4. Drug Screen				<input type="checkbox"/>	<input type="checkbox"/>	10. ECG
<input checked="" type="checkbox"/>	<input type="checkbox"/>	5. Lipids (40 Years +)				<input type="checkbox"/>	<input type="checkbox"/>	11. CVD Risk For 40 Yrs. & Above
<input checked="" type="checkbox"/>	<input type="checkbox"/>	6. Sickle Cell Test				<input type="checkbox"/>	<input type="checkbox"/>	12. HIV, Hepatitis Screening

OTHER FINDINGS (Physique, Scars, Disabilities, Mental Stability Including Behaviour, Etc.):

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		A 10 - crusting of ear from diet round		
Date: 30/10/2023	Name (Block Capitals). Dr. Dr-Buddhi	Signature: 		
GENERAL PRACTITIONER RUSAYL HEALTH CENTRE				
REVIEW/CONSULTATION: Status: Stable, Remains Stable				
Date: 30/10/2023	Name (Block Capitals). Dr.	Signature:		