



# مركز الرسيل الصحي RUSAYL HEALTH CENTRE

ISO 9001 - 2015 Certified Co.

No. B18109

## ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



**RUSAYL HEALTH CENTRE**  
ISO 9001 - 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL  
DETAILS IN BLOCK CAPITALS

Surname/ Forenames	AL YAQOUBI MUTAB KHALFAN
Nationality	OMANI
Company Number:	576
Reference Indicator:	TRUCK OMANI

Mobile No.	09140609
Home/Leave Address:	NIMR

Personal Details	CINIL ID: 3343764 DOB: 01/01/1979 AGE: 43
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A <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced /Widow(er)
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Home/Leave Address:	Relationship to employee <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	No of Children: 7
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Reason for Examination (tick as appropriate)

Periodic Medical Examination <input type="checkbox"/>	Final / Retirement <input type="checkbox"/>	Other Reason: <input type="checkbox"/>
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Employee only

B Present Job and Location: HEAVY DUTY DRIVER/NIMR	Next Job and Location: SAME
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Are you a registered person with special needs? <input type="checkbox"/>	Do you belong to any Medical Insurance Scheme? <input type="checkbox"/>
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**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		<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 your taken in the past?		<input checked="" type="checkbox"/>	
Do you smoke? If yes, what and how much each day?		<input checked="" type="checkbox"/>	
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"/>	WALKING

**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: 31/10/2022	Signature of Applicant:
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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
<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

170

WEIGHT  
kg

91

BMI

31.5

B.P.

170  
80

PULSE  
/mins.

70

HEARING  
L

N

R

N

VISION

DISTANT

NEAR

Uncorrected  
Corrected

R L  
6/6 6/6

R L  
6/6 6/6

N A

LABORATORY AND OTHER  
SPECIAL INVESTIGATIONS

N A

<input checked="" type="checkbox"/>		1. Urinalysis	<input checked="" type="checkbox"/>		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
		4. Drug Screen N/A	<input checked="" type="checkbox"/>		10. ECG
<input checked="" type="checkbox"/>		5. Lipids (40 years +)	<input checked="" type="checkbox"/>		11. CVS risk for 40 yrs. & above 2.1%
<input checked="" type="checkbox"/>		6. Sickie Cell test			12. HIV, Hepatitis screening

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

**ASSESSMENT AND RECOMMENDATIONS:**

☒ FIT ALL AREAS ☐ FIT WITH RESTRICTION ☐ TEMPORARY UNFIT ☐ UNFIT

Date: 8/10/20 Name (Block Capitals): Dr. / Nurse

Signature:

**REVIEW/CONSULTATION**

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

Signature:

