

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE
ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Surname/
Forenames

Yousuf Abdullah
Rashid Al Busaidi

Nationality

Omani

Mobile No. 98912846

Home/Leave Address: Sohar

Company Number: 10072

Reference Indicator:

Trakhtman

Personal Details

43y | DOB - 17,02,1980 | ID - 8884421

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:

Next Job and Location:

HDD

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		
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.

05/02/2023

Date: 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 189	WEIGHT kg 102	BMI 32	B.P. 112/84	PULSE 74/mins.	HEARING L R Uncorrected Corrected	VISION DISTANT R L 6/6		VISION NEAR R L 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.)

Adviser on蜒ant reuniton,

ASSESSMENT AND RECOMMENDATIONS:

FIT ALL AREAS FIT WITH RESTRICTION TEMPORARY UNFIT UNFIT

DR. SANATH BUDDHIKA PRIYADARSHAN
GENERAL PRACTITIONER
RUSAYL HEALTH CENTRE

05/02/2023

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


Signature:

REVIEW/CONSULTATION

Date:

Name (Block Capitals): Dr. / Nurse

Signature: