

#1372

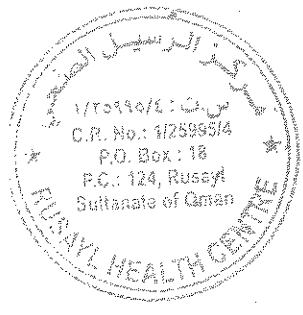
PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS



INITIAL EXAMINATION REPORT

Surname SENGH																																																																																																																																					
Forenames MANJIT																																																																																																																																					
Address TRUCKOMAN (STAFF-1372)																																																																																																																																					
Place of examination RS PATIENTS BAHJA	Date 04/09/19 DOB: 14/09/1981, CIVIL-72261426																																																																																																																																				
Home Telephone number 94246484																																																																																																																																					
If a dependant or fancee entr employees name jere :-																																																																																																																																					
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Nationality INDIAN	Country of birth INDIA Religion SIKHISM																																																																																																																																				
<input checked="" type="checkbox"/> Male <input checked="" type="checkbox"/> Single <input checked="" type="checkbox"/> Widow(er) <input checked="" type="checkbox"/> Female <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Divorced Separated	Relationship to employee <input checked="" type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Fiancee																																																																																																																																				
Number of Children 2																																																																																																																																					
Reason for examination <input checked="" type="checkbox"/> Pre-employment <input type="checkbox"/> Pre-overseas	Job :- DRIVER (HEAVY) Area:- BAHJA																																																																																																																																				
Name and address of family doctor	List your last 3 jobs																																																																																																																																				
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	(2)																																																																																																																																				
	(3)																																																																																																																																				
Are you Registered Disabled Person? (UK) <input type="checkbox"/>	Do you belong to any Medical Insurance Scheme? <input type="checkbox"/>																																																																																																																																				
DO YOU HAVE OR HAVE YOU HAD :- (Tick 'yes' or 'No' column or put a (?) If uncertain exclude minor ailmenis.)																																																																																																																																					
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42. Awarded benifities for Industrial injury/iltness	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N																																																																																																																																				
43. Treated for a mental condition. eg . depression	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N																																																																																																																																				
44. Treated for problem drinking or drug abuse	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N																																																																																																																																				
45. Exposed to toxic substance or noise	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N																																																																																																																																				
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Have you aver had:-																																																																																																																																					
46. An abnormal smear	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N																																																																																																																																				
47. Any gynaecological treatment	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N																																																																																																																																				
48. Are you pregnant?	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N																																																																																																																																				
49. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE ?	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N																																																																																																																																				
How much tabacco each day ? Non-smoker	Average daily alcohol consupction No																																																																																																																																				
Family history	Diabetes <input checked="" type="checkbox"/> Tuberculosis <input checked="" type="checkbox"/> Epilepsy <input checked="" type="checkbox"/> Asthama <input checked="" type="checkbox"/> Eczerna <input checked="" type="checkbox"/> Heart disease <input checked="" type="checkbox"/> High blood pressure <input checked="" type="checkbox"/> Stroke <input checked="" type="checkbox"/> Cancer <input checked="" type="checkbox"/> Blood disease <input checked="" type="checkbox"/>																																																																																																																																				
PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT :-																																																																																																																																					
I declare these statements to be true to the best of my knowledge and belief and I agree that the result of this medical in general terms may be revealed to the company if required, and the details sent to my own doctor if this is considered necessary by the examining medical officer.																																																																																																																																					
Date 04-09-19	Signature of applicant Mnith																																																																																																																																				

FOR COMPLETION BY EXAMINING DOCTOR OR SISTER
FURTHER DETAILS OF MEDICAL HISTORY AND RECREATIONAL ACTIVITIES

N - Normal A - Abnormal Please Describe			PHYSICAL EXAMINATION							
N	A		<p>BMT-29.1 kg/m² HR-77 bpm</p> 							
✓		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. Muscula-skeletal								
✓		12. Skin & Varicose Vns.								
✓		13. C.N.S.								
✓		14. Breasts								
		15.								
HEIGHT cm	WEIGHT kg	B.P.	HEARING L	HEARING R	VISION: Uncorrected	DISTANT R L	NEAR R L	COLOUR VISION	BLOOD GROUP	
165	79.1	134/94	L	R	Uncorrected	R L	R L	(N)		
			LABORATORY AND SPECIAL INVESTIGATIONS							
N	A		N A							
✓		1. Urinalysis	6. Audiogram							
✓		2. Hb Bloodcount ESR	7. Lung Function							
	✓	3. Serum Profile	8. Chest X-Ray							
		4. Stool	9. Drug Screen							
		5. E.C.G.	10. CR Screen							

BMT-29.1 kg/m²

OTHER FINDINGS (physique, scars, disabilities, mental stability etc.)

Advise

- Regular exercise
- Weight reduction.
- Take plenty of fruits & vegetables
- Avoid high fat diet

ASSESSMENT

☒ FIT ALL AREAS ☐ FIT HOME SERVICES ONLY ☐ UNFIT/UNSUITABLE ☐ MAY BE REASSESSED

Date 04.09.19

Signature

DR. HASAN MAHBUB KHAN BAYZID
MEDICAL OFFICER
RUSAYL HEALTH CENTRE
MOH LIC NO. 15691

Doctor / Sister

REVIEW/CONSULTATION

Date

Signature

Name (Block Capitals)

Doctor / Sister