



مركز الرسيل الصحي RUSAYL HEALTH CENTRE

ISO 9001 - 2015 Certified Co.

No. B16227

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE
ISO 9001 - 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Surname/Forenames: Hilal Mohammed Al Aamri		Nationality: Omani	
Mobile No. 79067782	Home/Leave Address: Muthaib	Company Number: 10095	Reference Indicator: Truckmen
Personal Details: 44y 1DOB 11,07,1978 ID-2832729			
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: HDD		Next Job and Location: NMMR	
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: 06/02/2022		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	NAD
		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.
171	71	24	118/82
		PULSE b/min.	HEARING
		66	L Normal
			R Normal
			Uncorrected
			Corrected
		VISION	
		DISTANT	
		R	L
		6/6	6/6
		NEAR	
		R	L
		6/6	6/6
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS	
		1. Urinalysis	
		2. Hb, Bloodcount, ESR	
		3. LFT, RFT, RBS	
		4. Drug Screen	
		5. Lipids (40 years +)	
		6. Sickie Cell test	
		7. Audiogram	
		8. Lung Function	
		9. Chest X-Ray	
		10. ECG	
		11. CVS risk for 40 yrs. & above	
		12. HIV, Hepatitis screening	

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

NAD

ASSESSMENT AND RECOMMENDATIONS:

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

DR. SANATH BODDITRAPPA NADARAHAN
GENERAL PRACTITIONER
RUSAYL HEALTH CENTRE
MOH LIC NO. 16042

Date: 06/02/2022 Name (Block Capitals): Dr. / Nurse

Signature:

REVIEW/CONSULTATION

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

Signature: