

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE
ISO 9001 - 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Surname/ Forenames	Ali Hamood & Khamsi		
Nationality	Omani		
Mobile No.	96586918	Home/Leave Address:	Jalan
Company Number:	10228	Reference Indicator:	Truck Oman
Personal Details			
A ☒ Male ☐ Female		☒ Married ☐ Single ☐ Separated /Divorced /Widow(er)	
Home/Leave Address:		Relationship to employee	No of Children:
		☐ Wife ☐ Son ☐ Daughter	
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: NIMV

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: 27/03/2022 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.

NAID

HEIGHT cm	WEIGHT kg	BMI	B.P.	PULSE mins.	HEARING L R	VISION DISTANT NEAR Uncorrected Corrected
169	85	30	114 84	60	Normal Normal	6/6 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. Sickie Cell test			12. HIV, Hepatitis screening

TG - 203
HDL - 30
LDL - 177

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

Assessed on weight reduction, low fat diet, regular exercise, station for 03 months

ASSESSMENT AND RECOMMENDATIONS:

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

Refer FCP after 03 months.

DR. SANATH BUDDHAKATPRITADARS
GENERAL PRACTITIONER
RUSAYL HEALTH CENTRE
MOH LIC NO. 16942

Date: 27/03/2022 Name (Block Capitals): Dr. / Nurse

Signature:

REVIEW/CONSULTATION

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

Signature: