

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE

ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Surname/Forenames *Abdullah Matar*  
Nationality *Oman*

*Sa'îm A'l Najabi*

Reference Indicator: *Trunk Oman*

Mobile No. <i>99794991</i>	Home/Leave Address: <i>Sohar</i>	Company Number: <i>10194</i>	Reference Indicator: <i>Trunk Oman</i>
Personal Details <i>48y</i>		<i>Dob - 01/01/1973 / DOB - 2042625</i>	
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)		
Home/Leave Address:	<input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	No of Children: <i>07</i>	

Reason for Examination (tick as appropriate)

Periodic Medical Examination  Final / Retirement  Other Reason:

Employee only

B Present Job and Location: <i>HD</i>	Next Job and Location: <i>NIMY</i>
Are you a registered person with special needs? <input type="checkbox"/>	Do you belong to any Medical Insurance Scheme? <input type="checkbox"/>

**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.

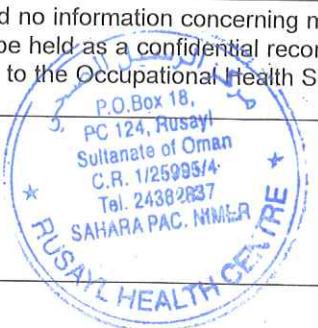
Please answer the following questions and tick 'N' (no) or 'Y' (yes) in the column. If 'Y' Please describe

	N	Y	Description
Have you, since your last medical been treated by your family doctor or specialist for significant (major) ailments?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
1 Ear, nose, eye or throat problems	<input type="checkbox"/>	<input type="checkbox"/>	
2 Chest problems like asthma, bronchitis, other bad cough	<input type="checkbox"/>	<input type="checkbox"/>	
3 Heart abnormality, chest pains	<input type="checkbox"/>	<input type="checkbox"/>	
4 Abdominal pains, abnormal bowel motions	<input type="checkbox"/>	<input type="checkbox"/>	
5 Urogenital problems (kidney disease, menstrual disorder)	<input type="checkbox"/>	<input type="checkbox"/>	
6 Skin trouble or allergies	<input type="checkbox"/>	<input type="checkbox"/>	
7 Epileptic fits, dizzy spells or migraine	<input type="checkbox"/>	<input type="checkbox"/>	
8 History of mental illness, depression anxiety	<input type="checkbox"/>	<input type="checkbox"/>	
9 Diabetes, thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	
10 Blood disorder e.g. anaemia, blood cancer e.g. leukaemia	<input type="checkbox"/>	<input type="checkbox"/>	
11 Any history of accidents or fractures	<input type="checkbox"/>	<input type="checkbox"/>	
12 Have you had any serious allergies	<input type="checkbox"/>	<input type="checkbox"/>	
13 Do any dependants have a significant ongoing illness?	<input type="checkbox"/>	<input type="checkbox"/>	
14 Any family history of cancers	<input type="checkbox"/>	<input type="checkbox"/>	
Do you take any regular medicines, or have you taken in the past?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you smoke? If yes, what and how much each day?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you drink alcohol? If yes, what is your average weekly intake?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever taken elicited/recreational drugs?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you doing regular sports or physical activities?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	

**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.

*27/12/2021*

Signature of Applicant: *[Signature]*



Date:

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	WEIGHT kg	BMI	B.P.	PULSE mins.	HEARING L R	HEARING R L	DISTANT R L	VISION R L
159	86	34	124/84	70	Normal Normal	Uncorrected Corrected	6/6	6/6

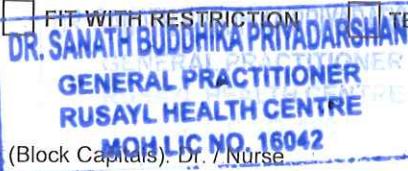
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A
✓		1. Urinalysis		7. Audiogram
✓		2. Hb, Bloodcount, ESR		8. Lung Function
✓		3. LFT, RFT, RBS		9. Chest X-Ray
✓		4. Drug Screen		10. ECG
✓		5. Lipids (40 years +)		11. CVS risk for 40 yrs. & above
✓		6. Sickle Cell test		12. HIV, Hepatitis screening

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

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over fat 25% R conin C larable.

ASSESSMENT AND RECOMMENDATIONS:

FIT ALL AREAS  FIT WITH RESTRICTION  TEMPORARY UNFIT  UNFIT



Date:

Name (Block Capitals): Dr. / Nurse

  
Signature:

REVIEW/CONSULTATION

Date:

Name (Block Capitals): Dr. / Nurse

Signature:

