



مركز الرسيل الصحي RUSAYL HEALTH CENTRE

ISO 9001 - 2015 Certified Co.

No. B18281

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE

ISO 9001 - 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Surname/
Forenames

Mehar Singh

Nationality

Indian

Mobile No.

72028292

Home/Leave Address:

2nd floor

Company Number:

1546

Reference Indicator:

Truckman

Personal Details

36 y

DOB

08.02.1985

ID-105214353

A ☒ Male ☐ Female

☒ Married

☐ Single

☐ Separated /Divorced /Widow(er)

Home/Leave Address:

Relationship to employee

☐ Wife

☐ Son

☐ Daughter

No of Children: 02

Reason for Examination (tick as appropriate)

Periodic Medical Examination ☒

Final / Retirement ☐

Other Reason: ☐

Employee only

B Present Job and Location:

Crane operator

Next Job and Location:

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 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 .

13/01/2022

Date:

Mehar Singh

Signature of Applicant:





مركز الرسيل الصحي RUSAYL HEALTH CENTRE

ISO 9001 - 2015 Certified Co.

No. B 18281

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.

NAD

HEIGHT cm	WEIGHT kg	BMI	B.P.	PULSE	HEARING	VISION
170	91.31		124 / 82	82 mins.	L Normal R Normal	DISTANT Uncorrected 6/6 Corrected 6/6

N	A		LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A	
		1. Urinalysis	TC-216			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. Sick Cell test				12. HIV, Hepatitis screening

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

A 21st 2021 low for diet
patient reaction, remember exercise.

ASSESSMENT AND RECOMMENDATIONS:

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

Date: 3/01/2022 Name (Block Capitals): Dr. / Nurse

Signature:

REVIEW/CONSULTATION

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

Signature:

