

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE  
ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

		Surname/Forenames		Benny Munduveli Thomas	
		Nationality		OM INZIAN TRUKKUAN	
Mobile No.	92012173	Home/Leave Address:	1212		Reference Indicator:
Personal Details		DOB - 08.05.1970 / ID - 75769176			
A <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced /Widow(er)			
Home/Leave Address:		Relationship to employee		No of Children: 02	
Reason for Examination (tick as appropriate)					
Periodic Medical Examination <input checked="" type="checkbox"/>		Final / Retirement <input type="checkbox"/>		Other Reason: <input type="checkbox"/>	

Employee only

B Present Job and Location: Operator	Next Job and Location: NIMR
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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

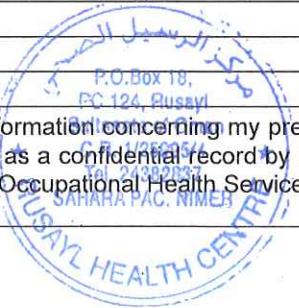
	N	Y	Description
Have you, since your last medical been treated by your family doctor or specialist for significant (major) ailments?	<input checked="" type="checkbox"/>		
1 Ear, nose, eye or throat problems	<input checked="" type="checkbox"/>		
2 Chest problems like asthma, bronchitis, other bad cough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

22/04/2021

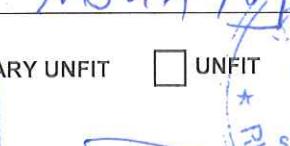
Date:

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									
		2. E.N.T.													
		3. Teeth & Mouth													
		4. Lungs & Chest													
		5. Cardiovascular System				NAD									
		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	VISION								
160		87	34	126 86	83	L Normal R Normal Uncorrected Corrected	DISTANT R L	6/6	NEAR R L	6/6					
N	A					LABORATORY AND OTHER SPECIAL INVESTIGATIONS				N	A				
		1. Urinalysis				FBS - 127 TC - 213						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 +)								TC		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.)															
<p>Advice on weight reduction, diet control, regular exercise, FBS monthly</p>															
ASSESSMENT AND RECOMMENDATIONS:															
<input type="checkbox"/> FIT ALL AREAS		<input type="checkbox"/> FIT WITH RESTRICTION		<input type="checkbox"/> TEMPORARY UNFIT		<input type="checkbox"/> UNFIT		<div style="text-align: right;">              P.O.Box 18,            PC 124, Rusayl            Sultanate of Oman            C.R. 1/25095/4            Tel. 24382837            SAHARA PAC. NIMER         </div>							
22/04/2021		DR SANATH BUDDHIKA PRYADARSHAN		GENERAL PRACTITIONER		RUSAYL HEALTH CENTRE		<div style="text-align: right;">              Signature: _____         </div>							
Date: Name (Block Capitals): DOCTOR NO. 16042															

#### **ASSESSMENT AND RECOMMENDATIONS:**

FIT ALL AREAS     FIT WITH RESTRICTION     TEMPORARY UNFIT

in follow up DR. SANATH BUDDHIKA PRIYADARSHI  
2/04/2021 GENERAL PRACTITIONER  
RUSAYL HEALTH CENTRE  
Date: Name (Block Capitals): DR. SANATH NO. 16042

Date: Sept 10

Name (Block Capitals): DR. NURSE

Signature:

P.O.Box 18,  
PC 124, Rusayl  
Sultante of Oman  
C.R. 1/25995/4  
Tel. 24382837  
HARA PAC. NIMR

## REVIEW/CONSULTATION

Date:

Name (Block Capitals): Dr. / Nurse

Signature: