مركز الرسيل الصحي
RUSAYL HEALTH CENTRE
ISO 9001- 2015 Certified Co.

No. B 19002

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)

RUSAYL HEALTH CENTRE
ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Surname/ Forenames	Shamsu Chyrakkat Sasi
Nationality	Indian Muthuman.
Mobile No. 79585226 / Home/Leave Address: Indian	Company Number: / Reference Indicator:

Personal Details 48Y | DoB - 30.04.1973 | ID - 77218749

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: N.M.V

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 .

22/02/2022 Shamsu

Date: **Signature of Applicant:**

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FOR COMPLETION BY EXAMINING DOCTOR OR NURSE

Further details of medical history and recreational activities

N	A	N = Normal A = Abnormal (please describe)	PHYSICAL EXAMINATION
		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
161	71	27	126/84	64 /mins.	L Normal R Normal	DISTANT R 6/6 L 6/6 NEAR R 6/6 L 6/6 Uncorrected Corrected

N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A	
✓		1. Urinalysis	TC-231	✓	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.)

Advised on low fat & Diet.
Regular Exercise

ASSESSMENT AND RECOMMENDATIONS:

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

22/02/2022

DR SAMATH BUDDHIKA PRIYADARSHAN
GENERAL PRACTITIONER
RUSAYL HEALTH CENTRE
MOH LIC NO. 16042

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

REVIEW/CONSULTATION

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