



مركز الرسيل الصحي RUSAYL HEALTH CENTRE

ISO 9001 - 2015 Certified Co.

No. B 09690

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE

ISO 9001 - 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Surname/Forenames: Shaukat Ali Khan
Sher Ahmed Khan
Nationality: Pakistan
Company Number: 6331 Reference Indicator: Truckman

Mobile No: 99057166 Home/Leave Address: Pakistan

Personal Details: 47y DOB - 01/11/1974 ID - 69164665

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: NIMY

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: 03/10/2021 Signature of Applicant: [Signature]





مرکز الرسیل الصحي RUSAYL HEALTH CENTRE

ISO 9001 - 2015 Certified Co.

No. B 09690

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	HEARING	VISION
183	80	24	130/90	66/min.	L normal R normal	DISTANT R L Uncorrected 6/6 Corrected 6/6

N	A		LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A	
✓		1. Urinalysis		✓		7. Audiogram
✓		2. Hb, Bloodcount, ESR	TC-241			8. Lung Function
✓		3. LFT, RFT, RBS	TC-208			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.)

medications started for HTN
A2 visit on regular follow up, Low for A2 visit
Regular exercise.

ASSESSMENT AND RECOMMENDATIONS:

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

with medical follow up.

Date: 03/10/2021

Name (Block Capitals): Dr. / Nurse

Signature:

REVIEW/CONSULTATION

Date:

Name (Block Capitals): Dr. / Nurse

Signature:

