



مركز الرسيل الصحي RUSAYL HEALTH CENTRE

ISO 9001- 2015 Certified Co.

No. B 07949

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE
ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Surname/ Forenames **MOTHIB ULLAH HOSON ALI**

Nationality **Bangladeshi** **30/M**

Mobile No. **94939357**

Home/Leave Address:

Bangladesh

Company Number: **1603**

Reference Indicator:

Personal Details

CVI : 107026648

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:

Helper - Nimi Marmul

Next Job and Location:

Helper - Truck Oman

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	<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 your 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"/>		Occasional
Have you ever taken elicited/recreational drugs?	<input checked="" type="checkbox"/>		
Are you doing regular sports or physical activities?	<input checked="" type="checkbox"/>		

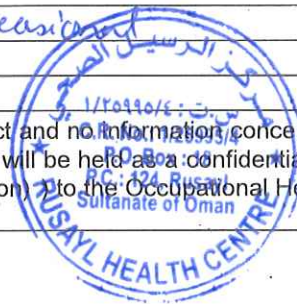
STATEMENT: I have read the above questions and the above answers are correct and no information concerning my present or past state of health has been withheld. I understand and agree that this form will be held as a confidential record by PDO Medical Department, and may be copied (by paper or secure electronic transmission) to the Occupational Health Services for the purpose of Health Surveillance and other Occupational Health review.

Date:

17/7/2021

Signature of Applicant:

[Signature]





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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	pink conjunctivae
✓		2. E.N.T.	
✓		3. Teeth & Mouth	
✓		4. Lungs & Chest	
✓		5. Cardiovascular System	Normal aortic + aortic, No murmur
✓		6. Abdo. Viscera	
✓		7. Hernial Orifices	
✓		8. Anus & Rectum	
✓		9. Genito-urinary	
✓		10. Extremities	
✓		11. Musculo-skeletal	
✓		12. Skin & Varicose Vns.	No jaundice
✓		13. C.N.S.	

HEIGHT cm	WEIGHT kg	BMI	B.P.	PULSE /mins.	HEARING L R	VISION DISTANT NEAR R L R L
159	67	26.5 OW	120 80	60	L (N) R (N)	Uncorrected Corrected 6/6 6/6 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 +)	TC 235.4, LDL 161			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.)

As Dyslipidemia

ASSESSMENT AND RECOMMENDATIONS:

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

Date:

Name (Block Capitals): Dr. / Nurse

DR. ROMMEL W. MELENDRES
MEDICAL OFFICER
RUSAYL HEALTH CENTRE
MOB. NO. 13982

Signature:



REVIEW/CONSULTATION

low-fat diet, exercise; Repeat lipid profile test after 3-6 mos

Date: 17/7/2021 Name (Block Capitals): Dr. / Nurse

Signature: