

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

28028



العيادة الرسمية
RUSAYL HEALTH CENTRE
NUWAR, FAHUD, QARNALAY, BHAJA, SAHRIWAL, MARYUL

INITIAL EXAMINATION REPORT

Place of examination	Date	25/8/18	Home Telephone number	1003 1/1/1981
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If a dependant or fiancee entr employees name jere :-

Surname :

Forenames:

	Nationality	Pakistan	Country of birth	Pakistan	Religion	Muslim
<input checked="" type="checkbox"/> Male	<input type="checkbox"/> Single	<input type="checkbox"/> Widow(er)	Relationship to employee			Number of Children
<input type="checkbox"/> Female	<input checked="" type="checkbox"/> Married	<input type="checkbox"/> Divorced Separated	<input type="checkbox"/> Wife	<input type="checkbox"/> Son	<input type="checkbox"/> Daughter	<input type="checkbox"/> Fiancee

Reason for examination

Pre-employment

Job :-

PDO medical

Pre-overseas

Area:-

Helper

Name and address of family doctor	List your last 3 jobs
	(1)
	(2)
	(3)

Are you Registered Disabled Person? (UK)

Do you belong to any Medical Insurance Scheme?

DO YOU HAVE OR HAVE YOU HAD :- (Tick "yes" or "No" column or put a (?) If uncertain exclude minor ailments.)

	Y	N		Y	N		Y	N
1. Sirius rouble		1	22. Heart Disease		1	42. Awarded benefits for Industrial injury/illness		1
2. Neck swellings/flands			23. Rheumatic Fever			43. Treated for a mental condition, eg . depression		
3. Difficulty in vision			24. Abnormal heartbeat			44. Treated for problem drinking or drug abuse		
4. Any ear discharge			25. High blood pressure			45. Exposed to toxic substance or noise		
5. Asthma/bronchitis			26. Stroke			FOR WOMEN ONLY		
6. Hayfever/other allergy			27. Serious chest pain			Have you ever had:-		
7. Any skin trouble			28. Any blood disease			46. An abnormal smear		
8. Tuberculosis			29. Kidney disease			47. Any gynaecological treatment		
9. Shortness of breath			30. Painful passage of urine			48. Are you pregnant?		
10. Coughed/vomited blood			31. Blood in urine			49. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE ?		1
11. Severe abdominal pain			32. Diabetes					
12. Stomach ulcer			33. Headaches /migraine					
13. Recurrent indigestion			34. Dizziness/tainting					
14. Jaundice or hepatitis			35. Epilepsy					
15. Gall bladder disease			36. Joints/spinal trouble					
16. Marked change in bowel habits			37. Surgical operation					
17. Blood in stools (motions)			38. Serious accident /fracture					
18. Marked change in weight			39. Tropical disease					
19. Varicose veins			40. Fear of heights					
20. Lump in breast/armpit			HAVE YOU EVER BEEN:-					
21. Cancer			41. Rejected for employment or insurance for medical reasons					

How much tobacco each day ?

None

Average daily alcohol consuption

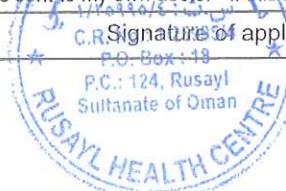
None

Family history	Diabetes <input checked="" type="checkbox"/>	Tuberculosis <input checked="" type="checkbox"/>	Epilepsy <input checked="" type="checkbox"/>	Asthama <input checked="" type="checkbox"/>	Eczema <input checked="" type="checkbox"/>	Cancer <input checked="" type="checkbox"/>	Blood disease <input checked="" type="checkbox"/>
	Heart disease <input checked="" type="checkbox"/>	High blood pressure <input checked="" type="checkbox"/>		Stroke <input checked="" type="checkbox"/>			

PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT :-

I declare these statements to be true to the best of my knowledge and belief and I agree that the result of this medical in general terms may be revealed to the company if required, and the details sent to my own doctor if this is considered necessary by the examining medical officer.

Date



B. Z. *[Signature]*

FOR COMPLETION BY EXAMINING DOCTOR OR SISTER
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. Muscula-skeletal									
	12. Skin & Varicose Vns.									
	13. C.N.S.									
	14. Breasts									
	15.									
HEIGHT cm	WEIGHT kg	B.P.	HEARING L	HEARING L	VISION: Uncorrected	DISTANT R 6 L 6	NEAR R 6 L 6	COLOUR VISION	BLOOD GROUP	
164	66	110/70	R an	R an	Corrected	6/6	6/6	6/6		
N	A	LABORATORY AND SPECIAL INVESTIGATIONS								
		1. Urinalysis								6. Audiogram
		2. Hb Bloodcount ESR								7. Lung Function
		3. Sarum Profile								8. Chest X-Ray
		4. Stool								9. Drug Screen
		5. E.C.G.								10. CR Screen
		BMI - 24.5								

ASSESSMENT

FIT ALL AREAS

1

FIT HOME SERVICES ON

ILK ~~ASAS~~ UNFIT/UNSUITABLE

MAY BE REASSESSED

Date 25/8/18

Doctor / Sister

REVIEW/CONSULTATION

Name (Block Capitals)

Date

Signature

Name (Block Capitals)

Doctor / Sister