

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

1414

DOB 01/02/1986
CNIL-78247305



مركز الرسيل الصحي
RUSAYL HEALTH CENTRE
NIMR, FAHUD, QARNALAM, BHAJA, SAHRIWAL, MARVUL

INITIAL EXAMINATION REPORT

Place of examination RS PAC CLINIC BHAJA	Date 27-04-19	Surname SADANANDAN
		Forenames SADAN
		Address TRUCK OMAN
		Home Telephone number 9579 26 31

If a dependant or fancee entr employees name jere :-

Surname :

Forenames:

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

Reason for examination
☒ Pre-employment
☐ Pre-overseas

Job :- **ELECTRICIAN**
 Area:- **BHAJA**

Name and address of family doctor

List your last 3 jobs



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 ailmenis.)

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

How much tabacco each day ?

Non-smoker

Average daily alcohol consupition

Family history	Diabetes <input checked="" type="checkbox"/>	Tuberculosis <input checked="" type="checkbox"/>	Epilepsy <input checked="" type="checkbox"/>	Asthama <input checked="" type="checkbox"/>	Eczerna <input checked="" type="checkbox"/>
	Heart disease <input checked="" type="checkbox"/>	High blood pressure <input checked="" type="checkbox"/>	Stroke <input checked="" type="checkbox"/>	Cancer <input checked="" type="checkbox"/>	Blood disease <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 **27-04-19**

Signature of applicant

[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		<p>BME-21.9 kg/m² HR-83b/min</p> 									
✓		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 R	VISION: Uncorrected	DISTANT R L	NEAR R L	COLOUR VISION	BLOOD GROUP
			169	62.5	100/90	L	R	Corrected				
N	A	LABORATORY AND SPECIAL INVESTIGATIONS						N	A			
✓		1. Urinalysis									6. Audiogram	
✓		2. Hb Bloodcount ESR									7. Lung Function	
✓		3. Serum Profile									8. Chest X-Ray	
		4. Stool									9. Drug Screen	
		5. E.C.G.									10. CR Screen	

BME-21.9 kg/m² OTHER FINDINGS (physique, scars, disabilities, mental stability etc.)

ASSESSMENT

☒ FIT ALL AREAS ☐ FIT HOME SERVICES ONLY ☐ UNFIT/UNSUITABLE ☐ MAY BE REASSESSED

Date 28.04.19

Signature

DR. HASAN MAHBUB KHAN BAYZID
Name (Block Capitals)
MEDICAL OFFICER
RUSAYL HEALTH CENTRE
MOH LIC NO. 15691

Doctor / Sister

REVIEW/CONSULTATION

Date

Signature

Name (Block Capitals)

Doctor / Sister