



مركز الرسيل الصحي RUSAYL HEALTH CENTRE

ISO 9001- 2015 Certified Co.

No. B **13037**

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE
ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Surname/ Forenames	NASSER HALSAIN
Nationality	KABULISTANI
Company Number:	Reference Indicator:

Mobile No. 9088116	Home/Leave Address:
---------------------------	---------------------

Company Number:	Reference Indicator:
-----------------	----------------------

Personal Details	46	Civil ID - 90851594
------------------	-----------	----------------------------

A <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced /Widow(er)
--	--

Home/Leave Address:	Relationship to employee <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	No of Children: 2
---------------------	--	--------------------------

Reason for Examination (tick as appropriate)

Periodic Medical Examination <input checked="" type="checkbox"/>	Final / Retirement <input type="checkbox"/>	Other Reason: <input type="checkbox"/>
--	---	--

Employee only

B Present Job and Location: HDD, FREELANCE	Next Job and Location:
--	------------------------

Are you a registered person with special needs? <input type="checkbox"/>	Do you belong to any Medical Insurance Scheme? <input type="checkbox"/>
--	---

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: 20/09/23	Signature of Applicant:
-----------------------	-------------------------

DR. CHIEMEKA NDUKA EKEGHE
GENERAL PRACTITIONER
RUSAYL HEALTH CENTRE
MOH LIC NO. 19798

مركز الرسيل الصحي
RUSAYL HEALTH CENTRE
C.R. No.: 1259954, 1261104 : س.ر.
P.O. Box : 18, P.C.: 124, Rusayl
Sultanate of Oman
RS PAC MURMUL CLINIC



مركز الرسيل الصحي RUSAYL HEALTH CENTRE

ISO 9001 - 2015 Certified Co.

No. B 13037

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	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	1. Eyes & Pupils
<input checked="" type="checkbox"/>	<input type="checkbox"/>	2. E.N.T.
<input checked="" type="checkbox"/>	<input type="checkbox"/>	3. Teeth & Mouth
<input checked="" type="checkbox"/>	<input type="checkbox"/>	4. Lungs & Chest
<input checked="" type="checkbox"/>	<input type="checkbox"/>	5. Cardiovascular System
<input checked="" type="checkbox"/>	<input type="checkbox"/>	6. Abdo. Viscera
<input checked="" type="checkbox"/>	<input type="checkbox"/>	7. Hernial Orifices
<input checked="" type="checkbox"/>	<input type="checkbox"/>	8. Anus & Rectum
<input checked="" type="checkbox"/>	<input type="checkbox"/>	9. Genito-urinary
<input checked="" type="checkbox"/>	<input type="checkbox"/>	10. Extremities
<input checked="" type="checkbox"/>	<input type="checkbox"/>	11. Musculo-skeletal
<input checked="" type="checkbox"/>	<input type="checkbox"/>	12. Skin & Varicose Vns.
<input checked="" type="checkbox"/>	<input type="checkbox"/>	13. C.N.S.

HEIGHT cm	WEIGHT kg	BMI	B.P.	PULSE /mins.	HEARING L R	VISION DISTANT NEAR R L
186	100	28.9	120/70	74	8/8	Uncorrected 6/6 6/6 Corrected 6/6 6/6

N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	1. Urinalysis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	7. Audiogram
<input checked="" type="checkbox"/>	<input type="checkbox"/>	2. Hb, Bloodcount, ESR	<input checked="" type="checkbox"/>	<input type="checkbox"/>	8. Lung Function
<input checked="" type="checkbox"/>	<input type="checkbox"/>	3. LFT, RFT, RBS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	9. Chest X-Ray
<input checked="" type="checkbox"/>	<input type="checkbox"/>	4. Drug Screen	<input checked="" type="checkbox"/>	<input type="checkbox"/>	10. ECG
<input checked="" type="checkbox"/>	<input type="checkbox"/>	5. Lipids (40 years +)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	11. CVS risk for 40 yrs. & above
<input checked="" type="checkbox"/>	<input type="checkbox"/>	6. Sickle Cell test	<input checked="" type="checkbox"/>	<input type="checkbox"/>	12. HIV, Hepatitis screening

OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)

overweight
Dyslipidaemia
Elevated Liver Enzymes
SGPT 100

ASSESSMENT AND RECOMMENDATIONS:

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

Fit to work

Cardiology fitness NMC 5/3/23 Cardiology fitness / Int/ Echo
Gastroenterology fitness NMC 7/3/23 Gastroenterology fitness required
Diagnosed at NMC

Date: 9/3/23 Name (Block Capitals): Dr. / Nurse Signature: [Signature]

REVIEW/CONSULTATION

NMC TX Regular process
Lipanthyl OD 1/3/2
Flp repeat in 3 months
Advised to take medicine at prescribed

Date: 9/3/23 Name (Block Capitals): Dr. / Nurse Signature: [Signature]

DR. CHIEMEKA NDUKA EKEGHE
GENERAL PRACTITIONER
RUSAYL HEALTH CENTRE
MOH LIC NO. 19798

Fitness to Work Certificate for drivers

Employee Data		Date 26/2/23	
Name NASSER Hussam		Department/Company Fullonmas	
ID No. 90881094	Age 46	Occupation HDB	
Type of Medical Evaluation		Mark those applying ✓	
A5- HVD- Crane or forklift driving & all heavy vehicles		A7- Professional driving light vehicles	
<p>Health Advisor Statement: The above named person has been examined according to the statements laid down in "Protocols and Guidance Notes on the Medical Evaluation of Fitness to Work". At this time his/her fitness to work status for the above tasks is as follows.</p>			
Fit with no restrictions		✓	
Fit with following restriction(s)			
The employee is fit for above work but should avoid the following task(s)	Temporary restriction	Permanent restriction	
Work near moving machinery or sharp edges			
Operate Heavy motor vehicles, forklifts or heavy machinery			
Other (Specify)			
Temporary Unfit until			
Permanently Unfit			
Name of health advisor		Signature 26/2/23	

DR. CHIEMEKA NDUKA EKEGHE
GENERAL PRACTITIONER:
RUSAYL HEALTH CENTRE:
MOH. NO. 19798

مركز الرسيل الصحي
RUSAYL HEALTH CENTRE
C.R. No.: 1259954, 1701105
P.O. Box : 18, P.C.: 124, Rusayl
Sultanate of Oman
RS PAC MURMUL CLINIC

11.20 Appendix 20: (Form SQ5): Epworth Screening Quest. for Sleep Apnoea

Employee Data		Date: 28/12/23
Name: Nasser Hussein		Department/Company: Puckman
I.D No. 90851094	Te # 72033116	Occupation: HDD

This questionnaire will help identify if you have any health condition which may need a more detailed medical assessment as part of your fitness to work determination. If you have any queries please contact your local Health Services staff. All information provided on this form and during consultations remains strictly confidential. When further clinical evaluation is required following completion of a screening questionnaire, the details should be recorded on Q1 and E1 forms.

How likely are you to fall asleep in the following situations? (use 0 to 3 score as shown below)


- 0 Would never doze
- 1 Slight chance of dozing
- 2 Moderate chance of dozing
- 3 High chance of dozing

☐ sitting and reading
☐ watching TV
☐ sitting inactive in a public place (e.g. theatre or meeting)
☐ as a passenger in the car for an hour without a break
☐ Lying down to rest in the afternoon when circumstances permit
☐ Sitting a talking with someone
☐ Sitting quietly after lunch without alcohol
☐ In a car, while stopped for a few minutes in traffic

Total 2

If you score a total of 15 or more you should seek advice from medical personnel on site before continuing to drive or operate machinery in the workplace.

Declaration: I, Nasser Hussein (Print Name) certify that to the best of my knowledge the above information supplied by me is true and correct.

Signature:  **Date:** 28/12/23

