

**ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)**



# RUSAYL HEALTH CENTRE

ISO 9001-2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL  
DETAILS IN BLOCK CAPITALS

Mobile No. <u>9088116</u>	Home/Leave Address: <u>46</u>	Company Number: <u>ANIL P - 96851094</u>	Reference Indicator:
<b>Personal Details</b>			
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: <u>2</u>
Reason for Examination (tick as appropriate)			
Periodic Medical Examination <input checked="" type="checkbox"/>	Final / Retirement <input type="checkbox"/>	Other Reason: <input type="checkbox"/>	
<b>Employee only</b>			
B Present Job and Location: <u>WDD, Trelleborgs</u>		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"/>	
<b>Previous Medical History:</b> 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.			
<b>Please answer the following questions and tick 'N' (no) or 'Y' (yes) in the column. If 'Y' Please describe</b>			
	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 <b>Have you had any serious allergies</b>		<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 you taken in the past?		<input checked="" type="checkbox"/>	
Do you smoke? If yes, what and how much each day?		<input checked="" type="checkbox"/>	<u>oldathwadha</u>
Do you drink alcohol? If yes, what is your average weekly intake?		<input checked="" type="checkbox"/>	
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: \_\_\_\_\_

26/09/23

Signature of Applicant:



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 /mins.	HEARING L R	Uncorrected Corrected	DISTANT R L	NEAR R L	VISION
186	100	28.9	128/7	74	L R	Uncorrected Corrected	6/6 6/6	6/6 6/6	

N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A
		1. Urinalysis		
		2. Hb, Bloodcount, ESR		
		3. LFT, RFT, RBS		
		4. Drug Screen		
		5. Lipids (40 years +)		
		6. Sickle Cell test		



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

overweight

dylipidemia

Elevated Liver enzymes

SGPT 100

ASSESSMENT AND RECOMMENDATIONS:

FIT ALL AREAS  FIT WITH RESTRICTION  TEMPORARY UNFIT  UNFIT

Fit to work

Radiology FITNESS NMC 5/5/23

Gastroenterology FITNESS NMC 7/3/23

Cardiology FITNESS NMC 5/5/23

Endocrinology FITNESS NMC 7/3/23

Neurology FITNESS NMC 5/5/23

Orthopaedics FITNESS NMC 5/5/23

Urology FITNESS NMC 5/5/23

Obstetrics & Gynaecology FITNESS NMC 5/5/23

Paediatrics FITNESS NMC 5/5/23

Psychiatry FITNESS NMC 5/5/23

Pharmacy FITNESS

## Fitness to Work Certificate for drivers

Employee Data		Date	26/2/23																									
Name	NASSER HUSSAIN																											
I.D No.	96887094	Age	46																									
Type of Medical Evaluation		Occupation																										
A6- HVD- Crane or forklift driving & all heavy vehicles		A7- Professional driving-light vehicles																										
<p><b>Health Advisor Statement:</b> 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> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px;">Fit with no restrictions</td> <td style="width: 50%; padding: 5px;">✓</td> </tr> <tr> <td colspan="2" style="padding: 5px;">Fit with following restriction(s)</td> </tr> <tr> <td style="padding: 5px;">The employee is fit for above work but should avoid the following task(s)</td> <td style="padding: 5px;">Temporary restriction</td> <td style="padding: 5px;">Permanent restriction</td> </tr> <tr> <td style="padding: 5px;">Work near moving machinery or sharp edges</td> <td style="padding: 5px;"> </td> <td style="padding: 5px;"> </td> </tr> <tr> <td style="padding: 5px;">Operate Heavy motor vehicles, forklifts or heavy machinery</td> <td style="padding: 5px;"> </td> <td style="padding: 5px;"> </td> </tr> <tr> <td style="padding: 5px;">Other (Specify)</td> <td style="padding: 5px;"> </td> <td style="padding: 5px;"> </td> </tr> <tr> <td colspan="3" style="padding: 5px;">Temporary Unfit until</td> </tr> <tr> <td colspan="3" style="padding: 5px;">Permanently Unfit</td> </tr> <tr> <td colspan="2" style="padding: 5px;">Name of health advisor</td> <td style="padding: 5px;">DR. CHIEMEKA NDUKA EKEGHE GENERAL PRACTITIONER RUSAYL HEALTH CENTRE MOH Signature: Date: 26/2/23</td> </tr> </table>				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		DR. CHIEMEKA NDUKA EKEGHE GENERAL PRACTITIONER RUSAYL HEALTH CENTRE MOH Signature: Date: 26/2/23
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## 11.20 Appendix 20: (Form SQ5): Epworth Screening Quest. for Sleep Apnoea

Employee Data	Date:	26/12/23
Name: <u>NABER Hassen</u>	Department/Company:	PECOKMAN
I.D No. <u>90851094</u>	Te #	<u>203316</u>
Occupation: <u>HDD</u>		

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

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

Total 1

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, NABER Hassen (Print Name) certify that to the best of my knowledge the above information supplied by me is true and correct.

Signature: 

Date: 26/12/23

