

1416

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS



مركز الرعاية الصحية
RUSAYL HEALTH CENTRE
NIMR, FAHUD, QARNALAY, BHAJA, SAHRIWAL, MARJUL

INITIAL EXAMINATION REPORT

Place of examination Bahja	Date 5.3.19	Surname Santhosh sadanandan
Forenames DOB. 10-11-77, CN. 78247273		Address Track. Oman, Bahja, Haima.
Home Telephone number 96528806		

If a dependant or fancee entr employees name jere :-

Surname :

Forenames:

Naticality Indian	Country of birth India	Religion Hindu
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input checked="" type="checkbox"/> Married	<input type="checkbox"/> Widow(er) <input type="checkbox"/> Divorced <input type="checkbox"/> Separated
Relationship to employee <input checked="" type="checkbox"/> Wife <input checked="" type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Fiancee		Number of Children 2

Reason for examination
☒ Pre-employment
☐ Pre-overseas

Job :- **Rigger**

Area:- **Haima, Bahja**

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 ailmenis.)

	Y	N		Y	N		Y	N
1. Sirius rouble			22. Heart Disease			42. Awarded benifities for Industrial injury/illness		
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 aver 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 ?		
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 /tracture					
18. Marked change in weight			39. Tropical disease					
19. Varicose veins			40. Fear of heights					
20. Lump in breast/armplit			HAVE YOU EVER BEEN:-					
21. Cancer			41. Rejected for employment or insurance for medical reasons					

How much tabacco each day ?

NA

Average daily alcohol consupcion

NA

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

5.3.19

Signature of applicant

[Signature]

Doctor / Sister