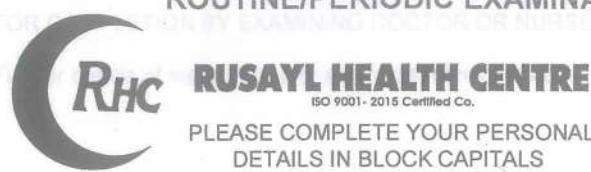


ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



Surname/
Forenames RAVEENDRAN PESI

Nationality INDIA

Company Number: 1423

Reference Indicator:

CIVIL ID - 74514571

Mobile No. 71287788 Home/Leave Address:

Personal Details

A Male Female Married Single Separated /Divorced /Widow(er)

Home/Leave Address: Wife Son Daughter No of Children: 1

Reason for Examination (tick as appropriate)

Periodic Medical Examination Final / Retirement Other Reason:

Employee only

B Present Job and Location: TRUCK DRIVER FORK LIFT OPERATOR, BAHRAIN Next Job and Location:

Are you a registered person with special needs? Do you belong to any Medical Insurance Scheme?

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		<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 Have you had any serious allergies		<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"/>		
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: 05/12/2021	Signature of Applicant: 
Dr. SURENDRA KUMAR EKEGHE GENERAL PRACTITIONER RUSAYL HEALTH CENTRE MOH LIC NO. 13798	



FOR COMPLETION BY EXAMINING DOCTOR OR NURSE

Further details of medical history and recreational activities

My posts Favorites

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. mmHg	PULSE /mins.	HEARING L (N) R (N)	VISION	
						DISTANT	NEAR
169	55	19	107 84	70	Uncorrected Corrected	6/6 6/6	6/6 L 6/6

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

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

Borderline High Uric acid.

ASSESSMENT AND RECOMMENDATIONS:

FIT ALL AREAS FIT WITH RESTRICTION TEMPORARY UNFIT UNFIT

Clinical

Yes * No

atherosclerosis:

Date: 05/12/2024 Name (Block Capitals): Dr. / Nurse: CHT MERA

Signature: 

REVIEW/CONSULTATION

Yes * No

Aneurysm:

Good / uric free diet Advised
Repeat uric acid / RFT in 6 months

Date: 05/12/2024 Name (Block Capitals): Dr. / Nurse: CHT MERA

Signature: 

GENERAL PRACTITIONER
RUSAYL HEALTH CENTRE
MOH LIC NO. 10798

