



ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE
ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Surname/ Forenames	Ramasamy Subramanian
Nationality	Indian
Company Number:	1334
Reference Indicator:	Frachman

Mobile No	95852151	Home/Leave Address:	Junig
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Personal Details	52y	DOB	05.10.1969	ID	61409065
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A	<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced /Widow(er)
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Home/Leave Address:	Relationship to employee	No of Children:
	<input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	02

Reason for Examination (tick as appropriate)

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

B Present Job and Location:	Next Job and Location:
Crane operator	Navy

Are you a registered person with special needs?	<input type="checkbox"/>	Do you belong to any Medical Insurance Scheme?	<input type="checkbox"/>
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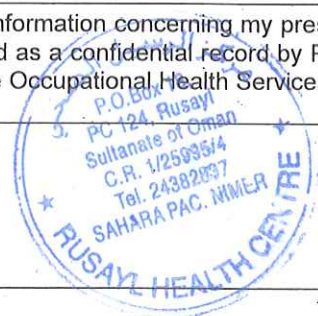
Previous Medical History: All important medical events should be listed and dated at every medical examination. To be completed together with the interviewing Nurses or Doctor who will be able to help by referring to your notes.

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?		<input checked="" type="checkbox"/>	
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 your 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:	03/10/2021	Signature of Applicant:	R. Sai
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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 16.1	WEIGHT kg 79	BMI 30.5	B.P. 130 90	PULSE 64/min.	HEARING L normal R normal	VISION	
					Uncorrected	DISTANT	NEAR
					Corrected	R L	R L
						0/6	0/6

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.)
 Medications started for HTN, A visit on regular follow up, low for exert. regular exercise.

ASSESSMENT AND RECOMMENDATIONS:
 FIT ALL AREAS FIT WITH RESTRICTION TEMPORARY UNFIT UNFIT
 with medications & follow up.
 Date: 03/10/2021 Name (Block Capitals): DR. SAJATH BUDDHIKA PRIYADARSHAN Signature:

REVIEW/CONSULTATION
 Date: Name (Block Capitals): Dr. / Nurse Signature:
 DR. SAJATH BUDDHIKA PRIYADARSHAN
 GENERAL PRACTITIONER
 RUSAYL HEALTH CENTRE
 MOH LIC NO. 16042

