

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE
ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Surname/Forenames	
GURIT SINGH	
Nationality	
INDIAN	

Mobile No. 97230484	Home/Leave Address:	Company Number: 1525	Reference Indicator: TRUCKOM 121
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Personal Details AGE - 36 yrs, DOB - 03-06-1985 CIVIL ID - 103178332

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:	<input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	No of Children: 2
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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: OPERATOR	Next Job and Location:
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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?				
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"/>		ON MEDICATION, NOT COMPLAINT
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"/>	<input checked="" type="checkbox"/>	AS ABOVE
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.

DR. INNOCENT IFEANYI NWOKEDIUKO
Date: 07/07/2021
GENERAL PRACTITIONER
RUSAYL HEALTH CENTRE
MOH LIC NO. 20062

Signature of Applicant:

Gurit Singh



FOR COMPLETION BY EXAMINING DOCTOR OR NURSE

known to be on medication not
Complaints Counselling on the need for
drug compliant and regular follow up on blood sugar.

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. 136 / 90	PULSE 92/mins.	HEARING L R	VISION DISTANT Uncorrected Corrected	NEAR R L	
189	113	31.6		4/4	6/6	6/6		
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS				N	A	
✓		1. Urinalysis	FBS - 161 mg/dl.					7. Audiogram
✗		2. Hb, Bloodcount, ESR	TCG - 22.8 mg/dl.					8. Lung Function
✓		3. LFT, RFT, RBS	FBS - 130 mg/dl.					9. Chest X-Ray
		4. Drug Screen NA						10. ECG
✓		5. Lipids (40 years +)						11. CVS risk for 40 yrs. & above
✓		6. Sickle Cell test NA						12. HIV, Hepatitis screening
OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.) Torsost 20mg daily, Repeat FLP in 3 months. 2 monthly FBS and at 3 monthly HAB HBA1C Advised, Drug compliance advised.								
ASSESSMENT AND RECOMMENDATIONS: <input checked="" type="checkbox"/> FIT ALL AREAS <input type="checkbox"/> FIT WITH RESTRICTION <input type="checkbox"/> TEMPORARY UNFIT <input type="checkbox"/> UNFIT								
<p>DR. INNOCENT IFEANYI NWOKEDIUKO GENERAL PRACTITIONER RUSAYL HEALTH CENTRE</p> <p>Date: Name (Block Capitals): Dr. / Nurse Signature: <i>[Signature]</i></p>								
REVIEW/CONSULTATION								
<p>Date: Name (Block Capitals): Dr. / Nurse Signature:</p>								