



مركز الرسائل الصحي RUSAYL HEALTH CENTRE

ISO 9001- 2015 Certified Co.

No. B 08274

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
Company Number:	1525 TRUCKOMAT
Reference Indicator:	

Mobile No. 97230484	Home/Leave Address:
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Personal Details	Age - 36 yrs, DOB - 03-06-1985, Civil ID - 103178332
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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 <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 your taken in the past?		<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 .

<p>Date: 02/07/2024</p> <p>DR. INNOCENT IFEANYI NWOKEDIUKO GENERAL PRACTITIONER RUSAYL HEALTH CENTRE MOH LIC NO. 20062</p>	<p>Signature of Applicant: Gurit Singh</p>	<p>P.O. Box 18, PC 124, Rusayl Sultanate of Oman C.R. 1/25996/4 Tel. 24382837 SAHARA PAC. HMLR</p> <p>RUSAYL HEALTH CENTRE</p>
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FOR COMPLETION BY EXAMINING DOCTOR OR NURSE

Further details of medical history and recreational activities

known DM on medication not
Compliant Counsellor 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.	PULSE	HEARING	VISION			
189	113	31.6	130 90	92/min.	L N R N	DISTANT	NEAR		
						R L	R L		
						Uncorrected	Corrected		
						6/6	6/6		

N	A		LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A	
✓		1. Urinalysis	FBS - 161 mg/dl. TC - 228 mg/dl. FBS - 130 mg/dl.			7. Audiogram
✓		2. Hb, Bloodcount, ESR				8. Lung Function
	✓	3. LFT, RFT, RBS				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.)

Torvast 20mg daily, Repeat FLP in 3 months.
2 monthly FBS and at 3 monthly HbA1c Advised, Drug compliance
Advised.

ASSESSMENT AND RECOMMENDATIONS:

☒ FIT ALL AREAS ☐ FIT WITH RESTRICTION ☐ TEMPORARY UNFIT ☐ UNFIT

DR. INNOCENT IFEANYI NWOKEDIUKO
GENERAL PRACTITIONER
RUSAYL HEALTH CENTRE

Date:

Name (Block Capitals): Dr. / Nurse

Signature:

REVIEW/CONSULTATION

Date:

Name (Block Capitals): Dr. / Nurse

Signature: