



MEDICAL EXAMINATION REPORT (CONFIDENTIAL)

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Surname	KHALIFA AL JAMOURI
Forenames	MUHAMMAD SAID
Address	19597406 - Trench Oman
Home telephone number	91142219

Place of examination	mut	Date	22/9/21
If a dependant enter employee's name here:			
Surname:		Forenames:	
Birth date:	29/9/89	Nationality:	Omani
Country of birth:		Oman	Religion:
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Married <input checked="" type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced	
<input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter		Relationship to employee Number of children:	
Reason for examination		Job: Driver	
<input type="checkbox"/> Pre-Employment <input type="checkbox"/> Periodic medical check-up <input type="checkbox"/> Pre-Overseas		Area:	
Name and address of family doctor		List your last 3 jobs	
		(1)	
		(2)	
		(3)	

Are you a Registered Disabled Person? (UK only)	<input type="checkbox"/>	Do you belong to any Medical Insurance Scheme?	<input type="checkbox"/>
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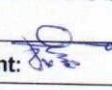
DO YOU HAVE OR HAVE YOU HAD:- (Tick "Yes" or "No" column or put a (?) if uncertain exclude minor ailments.)		Y		N		Y		N	
1. Sinus trouble				21. Cancer					
2. Neck swelling/glands				22. Heart Disease					
3. Difficulty in vision				23. Rheumatic fever					
4. Any ear discharge				24. Abnormal heartbeat					
5. Asthma/bronchitis				25. High blood pressure					
6. Hayfever /other significant allergy				26. Stroke					
7. Any skin trouble				27. Serious chest pain					
8. Tuberculosis				28. Any blood disease					
9. Shortness of breath				29. Kidney disease					
10. Coughed/vomited blood				30. Blood in urine					
11. Severe abdominal pain				31. Painful passage of urine					
12. Stomach ulcer				32. Diabetes					
13. Recurrent indigestion				33. Headaches/migraine					
14. Jaundice or hepatitis				34. Dizziness/fainting					
15. Gall Bladder disease				35. Epilepsy					
16. Marked change in bowel habits				36. Joints/spinal trouble					
17. Blood in stools (motions)				37. Surgical operation					
18. Marked change in weight				38. Serious accident/fracture					
19. Varicose veins				39. Tropical disease					
20. Lump in breast/armpit				40. Fear of heights					

How much tobacco each day?	1-5/day	Average daily alcohol consumption	No
Have you ever taken elicited drugs? ()			
FAMILY HISTORY: Diabetes () Tuberculosis () Epilepsy () Asthma () Eczema ()			
Heart disease () High blood pressure () Stroke () Blood Disease () Cancer ()			

PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT:-

I declared these statements to be true to the best of my knowledge and belief and I agree that the result of this medical examination 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: 22/9/21

Signature of Applicant: 



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.	
		14. Breast	

HEIGHT cm 181	WEIGHT kg 67	BMI 20.5	B.P (MMHG) 136/80	PULSE 78/min.	HEARING L R	VISION DISTANT R L NEAR R L Uncorrected Corrected 1/6 1/6	Colour Vision 2	Blood Group
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N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A
/		1. Urinalysis	/	
/		2. Hb, Bloodcount, ESR		7. Audiogram
/		3. LFT, RFT, RBS		8. Lung Function
/		4. Drug Screen		9. Chest X-Ray
/		5. Lipids (40 years +)		10. ECG
/		6. Sickie Cell test		11. CVS risk for 40 yrs. & above
				12. HIV, Hepatitis screening

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

ASSESSMENT:

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

Date: 22/19/2021 Name (Block Capitals): Dr. / Nurse

Signature:

Dr. ABULRAHMAN ABDULLATEF
General Practitioner
MOR: 19486

REVIEW/CONSULTATION

Date: Name (Block Capitals): Dr. / Nurse

Signature: