

#1460

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS



مركز الرعاية الصحية
RUSAYL HEALTH CENTRE
 NIMR, FAHUD, QARNALAK, BHAJA, SAHRIWAL, MARWUL

INITIAL EXAMINATION REPORT

Surname Abdul Rafeek Kunnapilly.
 Forenames DOB-12-11-81, EN. moideen
 Address #7283822

Place of examination Bahja Date 02-10-18
 Home Telephone number 95692507

If a dependant or fancee entr employees name jere :-
 Surname : _____ Forenames: _____

Nationality Indian Country of birth India Religion Islam
 Male Single Widow(er)
 Female Married Divorced Separated
 Relationship to employee Wife Son Daughter Fiancee
 Number of Children 2

Reason for examination Pre-employment Pre-overseas
POO medical Job :- DRIVER
 Area:- Bahja, Haina

Name and address of family doctor	List your last 3 jobs
	(1)
	(2)
	(3)

Are you Registered Disabled Person? (UK Do you belong to any Medical Insurance Scheme?

DO YOU HAVE OR HAVE YOU HAD :- (Tick 'yes' or 'No' column or put a (?) If uncertain exclude minor ailments.)

	Y	N		Y	N		Y	N
1. Sirius rouble		<input checked="" type="checkbox"/>	22. Heart Disease		<input checked="" type="checkbox"/>	42. Awarded benifities for Industrial injury/illness		<input checked="" type="checkbox"/>
2. Neck swellings/flands		<input checked="" type="checkbox"/>	23. Rheumatic Fever		<input checked="" type="checkbox"/>	43. Treated for a mental condition. eg . depression		<input checked="" type="checkbox"/>
3. Difficulty in vision		<input checked="" type="checkbox"/>	24. Abnormal heartbeat		<input checked="" type="checkbox"/>	44. Treated for problem drinking or drug abuse		<input checked="" type="checkbox"/>
4. Any ear discharge		<input checked="" type="checkbox"/>	25. High blood pressure		<input checked="" type="checkbox"/>	45. Exposed to toxic substance or noise		<input checked="" type="checkbox"/>
5. Asthma/bronchitis		<input checked="" type="checkbox"/>	26. Stroke		<input checked="" type="checkbox"/>	FOR WOMEN ONLY		
6. Hayfever/other allergy		<input checked="" type="checkbox"/>	27. Serious chest pain		<input checked="" type="checkbox"/>	Have you aver had:-		
7. Any skin trouble		<input checked="" type="checkbox"/>	28. Any blood disease		<input checked="" type="checkbox"/>	46. An abnormal smear		
8. Tuberculosis		<input checked="" type="checkbox"/>	29. Kidney disease		<input checked="" type="checkbox"/>	47. Any gynaecological treatment		
9. Shortness of breath		<input checked="" type="checkbox"/>	30. Painful passage of urine		<input checked="" type="checkbox"/>	48. Are you pregnant?		
10. Coughed/vomited blood		<input checked="" type="checkbox"/>	31. Blood in urine		<input checked="" type="checkbox"/>	49. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE ?		
11. Severe abdominal pain		<input checked="" type="checkbox"/>	32. Diabetes		<input checked="" type="checkbox"/>			
12. Stomach ulcer		<input checked="" type="checkbox"/>	33. Headaches /migraine		<input checked="" type="checkbox"/>			
13. Recurrent indigestion		<input checked="" type="checkbox"/>	34. Dizziness/tainting		<input checked="" type="checkbox"/>			
14. Jaundice or hepatitis		<input checked="" type="checkbox"/>	35. Epilepsy		<input checked="" type="checkbox"/>			
15. Gall bladder disease		<input checked="" type="checkbox"/>	36. Joints/spinal trouble		<input checked="" type="checkbox"/>			
16. Marked change in bowel habits		<input checked="" type="checkbox"/>	37. Surgical operation		<input checked="" type="checkbox"/>			
17. Blood in stools (motions)		<input checked="" type="checkbox"/>	38. Serious accident /tracture		<input checked="" type="checkbox"/>			
18. Marked change in weight		<input checked="" type="checkbox"/>	39. Tropical disease		<input checked="" type="checkbox"/>			
19. Varicose veins		<input checked="" type="checkbox"/>	40. Fear of heights		<input checked="" type="checkbox"/>			
20. Lump in breast/armpit		<input checked="" type="checkbox"/>	HAVE YOU EVER BEEN:-		<input checked="" type="checkbox"/>			
21. Cancer		<input checked="" type="checkbox"/>	41. Rejected for employment or insurance for medical reasons		<input checked="" type="checkbox"/>			

How much tabacco each day ? NA Average daily alcohol consuption NA

Family history Diabetes Tuberculosis Epilepsy Asthama Eczerna
 Heart disease High blood pressure Stroke Cancer Blood disease

PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT :-
 I declare these statements to be true to the best of my knowledge and belief and I agree that the result of this medical 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 02-10-18 Signature of applicant [Signature]

**FOR COMPLETION BY EXAMINING DOCTOR OR SISTER
FURTHER DETAILS OF MEDICAL HISTORY AND RECREATIONAL ACTIVITIES**

N - Normal A - Abnormal Please Describe		PHYSICAL EXAMINATION
N	A	<p><i>BMI: 20.90 kg/m²</i></p>
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HEIGHT cm <i>164</i>	WEIGHT kg <i>69</i>	B.P. <i>139/89</i> <i>mm Hg</i>	HEARING L R	HEARING L R	VISION: Uncorrected Corrected	DISTANT R L	NEAR R L	COLOUR VISION <i>⊙</i>	BLOOD GROUP
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N		A		LABORATORY AND SPECIAL INVESTIGATIONS	N		A		
/								6. Audiogram	
/									7. Lung Function
/									8. Chest X-Ray
									9. Drug Screen
									10. CR Screen

OTHER FINDINGS (physique, scars, disabilities, mental stability etc.)

BMI: Healthy wt.

ASSESSMENT

FIT ALL AREAS
 FIT HOME SERVICES ONLY
 UNFIT/UNSUITABLE
 MAY BE REASSESSED

Date *13-10-18* Signature *[Signature]*

DR. MOHAMMAD MARUF FERDOUS
 MEDICAL OFFICER
 RUSAYL HEALTH CENTRE
 MUH LIC NO. 12930

Doctor / Sister

REVIEW/CONSULTATION

Date

Signature

Name (Block Capitals)

Doctor / Sister

