مركز الرسيل الصحي
RHC RUSAYL HEALTH CENTRE
ISO 9001- 2015 Certified Co.

No. B 15516

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)

RHC RUSAYL HEALTH CENTRE
ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Surname/ Forenames	ABDUL RAFEEK KUMMAPILLY
Nationality	INDIAN
Mobile No. 71392587	Home/Leave Address:
Company Number:	Reference Indicator:
Personal Details	41 years
A ☐ Male ☐ Female	☑ Married ☐ Single ☐ Separated /Divorced /Widow(er)
Home/Leave Address:	Relationship to employee ☐ Wife ☐ Son ☐ Daughter
No of Children: 3	

Reason for Examination (tick as appropriate)

Periodic Medical Examination ☑ Final / Retirement ☐ Other Reason: ☐

Employee only

B Present Job and Location: H DD, TRUCK DRIVER	Next Job and Location:
Are you a registered person with special needs? ☐	Do you belong to any Medical Insurance Scheme? ☐

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	✓		
2	Chest problems like asthma, bronchitis, other bad cough	✓		
3	Heart abnormality, chest pains	✓		
4	Abdominal pains, abnormal bowel motions	✓		
5	Urogenital problems (kidney disease, menstrual disorder)	✓		
6	Skin trouble or allergies	✓		
7	Epileptic fits, dizzy spells or migraine	✓		
8	History of mental illness, depression anxiety	✓		
9	Diabetes, thyroid disease	✓		
10	Blood disorder e.g. anaemia, blood cancer e.g. leukaemia	✓		
11	Any history of accidents or fractures	✓		
12	**Have you had any serious allergies**	✓		
13	Do any dependants have a significant ongoing illness?	✓		
14	Any family history of cancers	✓		
Do you take any regular medicines, or have your taken in the past?		✓		
Do you smoke? If yes, what and how much each day?		✓		
Do you drink alcohol? If yes, what is your average weekly intake?		✓		
Have you ever taken elicited/recreational drugs?		✓		
Are you doing regular sports or physical activities?		✓		

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: 10/7/2022 **Signature of Applicant:**

DR. CHIEMEKA NDUKA EKEGHE
GENERAL PRACTITIONER
RUSAYL HEALTH CENTRE
MOH LIC NO. 13799

مركز الرسيل الصحي
س.ت: ١/٢٥٩٩٥٤/٤
C.R. No.: 1/2599514
P.O. Box : 18
P.C.: 124, Rusayl
Sultanate of Oman
RUSAYL HEALTH CENTRE

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FOR COMPLETION BY EXAMINING DOCTOR OR NURSE

Further details of medical history and recreational activities

N	A	N = Normal A = Abnormal (please describe)	PHYSICAL EXAMINATION
✓		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 /mins.	HEARING	VISION
165	69	25	150/110	89	L (N) R (N)	DISTANT R L: Uncorrected 6/6 6/6; Corrected 6/6 6/6. NEAR R L: N5 N5

N	A		LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A	
✓		1. Urinalysis	Total chol 240↑ HDL – 36↓ LDL – 182↑ SGPT – 58↑ FRS – 10%	✓		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.) Mild hypertension Diastolic hypertension Dyslipidemia Low HDL

ASSESSMENT AND RECOMMENDATIONS:

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

FIT

Date: 4/7/2020 Name (Block Capitals): Dr. / Nurse CHIEMEKA / TOBY Signature:

REVIEW/CONSULTATION

Torvast 10mg OD 3/12
Amlodipine 5mg OD 1/12
Low fat / Low salty diet
weekly BP check, LFT, FLP in 3 months

Date: 4/7/2020 Name (Block Capitals): Dr. / Nurse CHIEMEKA Signature:

DR. CHIEMEKA NDUKA EKECHE
GENERAL PRACTITIONER
RUSAYL HEALTH CENTRE
MOH LIC NO. 13798

مركز الرسيل الصحي
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C.R. No.: 1/2599514
P.O. Box : 18
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Sultanate of Oman
RUSAYL HEALTH CENTRE

Appendix 20: (Form SQ5): Epworth Screening Quest. for Sleep Apnoea

Employee Data		Date: 4/7/2020.
Name: ABDUL RAFEEK.		Department/Company: TRUCKMAN.
I. D No. 1283882	Tel # 71322587	Occupation : HDD

This questionnaire will help identify if you have any health condition which may need a more detailed medical assessment as part of your fitness to work determination. If you have any queries please contact your local Health Services staff. All information provided on this form and during consultations remains strictly confidential. When further clinical evaluation is required following completion of a screening questionnaire, the details should be recorded on Q1 and E1 forms.

How likely are you to fall asleep in the following situations? (use 0 to 3 score as shown below)

0 Would never doze

1 Slight chance of dozing

2 Moderate chance of dozing

3 High chance of dozing

0	sitting and reading
0	watching TV
0	sitting inactive in a public place (e.g. theatre or meeting)
0	as a passenger in the car for an hour without a break
1	Lying down to rest in the afternoon when circumstances permit
0	Sitting a talking with someone
0	Sitting quietly after lunch without alcohol
0	In a car, while stopped for a few minutes in traffic
Total	1

If you score a total of 15 or more you should seek advice from medical personnel on site before continuing to drive or operate machinery in the workplace.

Declaration: I, ABDUL RAFEEK *(Print Name)* certify that to the best of my knowledge the above information supplied by me is true and **correct.**

Signature: _____ **Date:** 4/7/2020.

DR. CHIEMEKA NDUKA EKECHE
GENERAL PRACTITIONER
RUSAYL HEALTH CENTRE
MOH LIC NO. 19798

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