

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

1404

DOB 08/10/1982
CIN 14-82690112



مركز الرعاية الصحية
RUSAYL HEALTH CENTRE
NIZR, FAHUD, QARNALAM, BHAJA, SAHRIWAL, MARJUL

INITIAL EXAMINATION REPORT

Place of examination RS PAC CLINIC BAHJA	Date 28/04/19	Surname SHAH-1464
Forenames JASWINDER SONWA		Address TRUK-OMAN
Home Telephone number 95398892		

If a dependant or fancee entr employees name jere :-

Surname : Forenames:

Nationality INDIAN	Country of birth INDIA	Religion SIKHISM
<input checked="" type="checkbox"/> Male <input checked="" type="checkbox"/> Female	<input checked="" type="checkbox"/> Single <input checked="" type="checkbox"/> Married	<input checked="" type="checkbox"/> Widow(er) <input type="checkbox"/> Divorced <input type="checkbox"/> Separated
Relationship to employee <input checked="" type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Fiancee		Number of Children 2

Reason for examination ☒ Pre-employment ☐ Pre-overseas

Job :- **DRIVER (HEAVY)**

Area:- **BAHJA**

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 uncerlain exclude minor ailmenis.)

	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		<input checked="" type="checkbox"/>
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/armpl		<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					

How much tabacco each day ? **1-2** Average daily alcohol consumption

Family history	Diabetes <input type="checkbox"/>	Tuberculosis <input checked="" type="checkbox"/>	Epilepsy <input type="checkbox"/>	Asthma <input checked="" type="checkbox"/>	Eczerna <input checked="" type="checkbox"/>
	Heart disease <input checked="" type="checkbox"/>	High blood pressure <input checked="" type="checkbox"/>	Stroke <input checked="" type="checkbox"/>	Cancer <input checked="" type="checkbox"/>	Blood disease <input checked="" type="checkbox"/>

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 **28-04-19** Signature of applicant **Jaswinder Singh**

Doctor / Sister