



# مركز الرسيل الصحي RUSAYL HEALTH CENTRE

ISO 9001- 2015 Certified Co.

No. B 08085

## ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



### RUSAYL HEALTH CENTRE

ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL  
DETAILS IN BLOCK CAPITALS

Surname/  
Forenames **MANOJ KOTTAMKUNNATH**

Nationality **INDIAN**

Mobile No. **94325698** Home/Leave Address:

Company Number:

Reference Indicator:

Personal Details **CIVIL NO. 167987563**

**DOB: 01/04/1976**

A ☒ Male ☐ Female

☒ Married ☐ Single ☐ Separated /Divorced /Widow(er)

Home/Leave Address:

Relationship to employee

☐ Wife ☐ Son ☒ Daughter

No of Children: **02**

Reason for Examination (tick as appropriate)

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

Employee only

**JOB: FORKLIFT OPERATOR**

B Present Job and Location:

**QARN ALAM**

Next Job and Location:

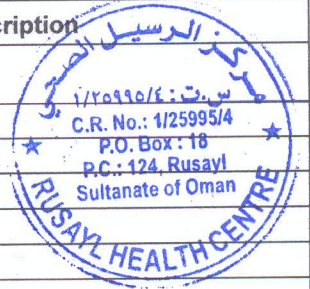
Are you a registered person with special needs? ☐ **NO**

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?	<input checked="" type="checkbox"/>		
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"/>		<b>T. GLUCOPHAGE 1000 mg</b>
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"/>		
Do you smoke? If yes, what and how much each day?	<input checked="" type="checkbox"/>		<b>5-6 STICKS / day</b>
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 .

Date:

**28.07.2021**

Signature of Applicant: