



TRUCK OMAN

Appendix 33: EX2 Form (Routine/Periodic Medical Examination)
ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

Ident 18596	Reg.Dt 01 04 2023	Ministry of Health MEDICAL DEPARTMENT	Surname/Forenames SYAMKUMAR SATHYAPALAN
Name SYAMKUMAR SATHYAPALAN		PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS	Nationality INDIAN, DOB - 18/10/1982
Gender Male	Nationality INDIAN	Mobile No. 94214630	Address: 79408268
		Company Number:	Reference Indicator:
Personal Details			
A <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		<input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced /Widow(er)	
Home/Leave Address:		Relationship to employee <input type="checkbox"/> Wife <input checked="" type="checkbox"/> Son <input checked="" type="checkbox"/> Daughter	No of Children: 2
Reason for Examination (tick as appropriate)			
Periodic Medical Examination <input checked="" type="checkbox"/> Final / Retirement <input type="checkbox"/> Other Reason: <input type="checkbox"/>			
Employee only			
B Present Job and Location: H.D DRIVER.		Next Job and Location:	
Are you a registered person with special needs? <input type="checkbox"/>		Do you belong to any Medical Insurance Scheme? <input type="checkbox"/>	
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, another 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, history of Hypertension	✓		DIABETIC ON MEDICATION
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 you taken in the past?	✓		Tab. ISTAMET D-XR-1000, T-LIPITAS 5mg.
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: 01/04/23.		Signature of Applicant:	





Further details of medical history and recreational activities

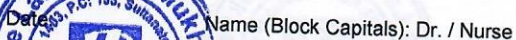
N = Normal A = Anormal (please describe)		PHYSICAL EXAMINATION									
N	A										
✓		1. Eyes & Pupils									
✓		2. E.N.T.									
✓		3. Teeth & Mouth									
✓		4. Lungs & Chest									
✓		5. Cardiovascular System									
✓		6. Abdo. Viscera									
✓		7. Hernial Orifices									
		8. Anus & Rectum									
✓		9. Genito-urinary									
✓		10. Extremities		SURGERY MARK ON LEFT ARM FROM 15 YEARS BACK.							
✓		11. Musculo-skeletal									
✓		12. Skin & Varicose Vns.									
✓		13. C.N.S.									
HEIGHT cm		WEIGHT kg	BMI	B.P.	PULSE	HEARING	VISION				Color Vision
175		89	29.06	130 80	82 /mins.	L N R N	DISTANT NEAR R L R L Uncorrected 6/6 6/6 Corrected				1 ✓ Normal 2. Anormal
N	A					LABORATORY AND OTHER SPECIAL INVESTIGATIONS				N	A
		1. Urinalysis									
		2. Hb, Blood count, ESR									
		3. LFT, RFT, RBS									
		4. Drug Screen									
		5. Lipids (40 years +)									
		6. Sickie Cell test									
								7. Audiogram			
								8. Lung Function			
								9. Chest X-Ray			
								10. ECG			
								11. CVS risk for 40 yrs. & above			
								12. HIV, Hepatitis screening			

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

Adv: Diet & Exercise
Weight Reduction

ASSESSMENT AND RECOMMENDATIONS:

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



REVIEW/CONSULTATION

Dr. ABDUL RAHMAN
MCH Medicine

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

Signature: