

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE
ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Surname/ Forenames	AL ABDULLAH SULTAN
Nationality	OMAN

Mobile No. 9990155401	Home/Leave Address:	Company Number:	Reference Indicator:
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Personal Details

A <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced /Widow(er)
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Home/Leave Address:	Relationship to employee	No of Children: 5
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Reason for Examination (tick as appropriate)

Periodic Medical Examination <input checked="" type="checkbox"/>	Final / Retirement <input type="checkbox"/>	Other Reason: <input type="checkbox"/>
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Employee only

B Present Job and Location: SUPERVISOR, TRUCK OWNER	Next Job and Location:
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Are you a registered person with special needs? <input type="checkbox"/>	Do you belong to any Medical Insurance Scheme? <input type="checkbox"/>
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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.

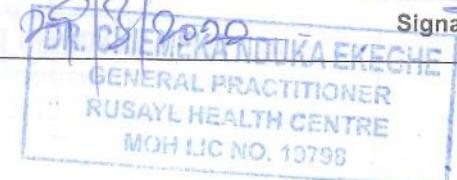
Please answer the following questions and tick 'N' (no) or 'Y' (yes) in the column. If 'Y' Please describe

	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	<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"/>		
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 you taken in the past?	<input checked="" type="checkbox"/>		
Do you smoke? If yes, what and how much each day?	<input checked="" type="checkbox"/>		
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: 08/08/2020

Signature of Applicant:



س.ت. 1/10990/4
C.R. No.: 1/2599/4
P.O. Box : 18
P.C.: 124, Rusayl
Sultanate of Oman



FOR COMPLETION BY EXAMINING DOCTOR OR NURSE

Further details of medical history and recreational activities

Framingham risk score calculator

Posted by doctor

N = Normal A = Abnormal (please describe)		PHYSICAL EXAMINATION										
N	A											
<input checked="" type="checkbox"/>	1. Eyes & Pupils											
<input checked="" type="checkbox"/>	2. E.N.T.											
<input checked="" type="checkbox"/>	3. Teeth & Mouth											
<input checked="" type="checkbox"/>	4. Lungs & Chest											
<input checked="" type="checkbox"/>	5. Cardiovascular System											
<input checked="" type="checkbox"/>	6. Abdo. Viscera											
<input checked="" type="checkbox"/>	7. Hernial Orifices											
<input checked="" type="checkbox"/>	8. Anus & Rectum											
<input checked="" type="checkbox"/>	9. Genito-urinary											
<input checked="" type="checkbox"/>	10. Extremities											
<input checked="" type="checkbox"/>	11. Musculo-skeletal											
<input checked="" type="checkbox"/>	12. Skin & Varicose Vns.											
<input checked="" type="checkbox"/>	13. C.N.S.											
HEIGHT cm	WEIGHT kg	BMI	B.P. /mins.	PULSE /mins.	HEARING L (N) R (W)	Uncorrected Corrected	DISTANT R 6/6 L 6/6	VISION NEAR R 6/6 L 6/6				
180	85	26	110 70	70								
N A				LABORATORY AND OTHER SPECIAL INVESTIGATIONS			N	A				
<input checked="" type="checkbox"/>	1. Urinalysis	Lymph - 59% ↑ MCH - 26% ↓ MCV - 30% ↓ TC - 177 N HDL - 51 N FRG - 2-8%							7. Audiogram			
<input checked="" type="checkbox"/>	2. Hb, Bloodcount, ESR								8. Lung Function			
<input checked="" type="checkbox"/>	3. LFT, RFT, RBS								9. Chest X-Ray			
<input checked="" type="checkbox"/>	4. Drug Screen								10. ECG			
<input checked="" type="checkbox"/>	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.)

bordeline overweight

ASSESSMENT AND RECOMMENDATIONS:

FIT ALL AREAS FIT WITH RESTRICTION TEMPORARY UNFIT UNFIT

FIT

Date: 09/3/2022 Name (Block Capitals): Dr. / Nurse

Signature: 

REVIEW/CONSULTATION

CHIEMKA

regular exercise

Date: 29/3/2022 Name (Block Capitals): Dr. / Nurse

Signature: 

GENERAL PRACTITIONER
RUSAYL HEALTH CENTRE
MOH LIC NO. 10798

