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Appendix 33: EX2 Form (Routine/Periodic Medical Examination)

tient 20663 Reg.Dt 04/09/2023
me HUMAID OMAIR HILAL AL HINAI
nder Male Nationality OMANI

OUTINE/PERIODIC EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

leum Development Oman
DICAL DEPARTMENT

Surname/ Forenames: HUMAID OMRI AL HINAI

Nationality: OMANI # DOB: -08/04/1974

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Mobile No: 99374423 Address: 2228397 Company Number: 315 Reference Indicator:

Personal Details

A ☑ Male ☐ Female ☑ Married ☐ Single ☐ Separated /Divorced /Widow(er)

Home/Leave Address: Relationship to employee ☐ Wife ☐ Son ☐ Daughter No of Children:

Reason for Examination (tick as appropriate)

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

Employee only

B Present Job and Location: PRO HAMRA 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, 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	√	✓	DM and HTN 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 your taken in the past?		√	✓	T. METFORMIN 1gm BD, T. LISINOPRIL 5mg OD T. GLICLAZIDE 80mg OD
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: 04/09/2023 Signature of Applicant:

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Appendix 33: EX2 Form (Routine/Periodic Medical Examination)

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

FOR COMPLETION BY EXAMINING DOCTOR OR NURSE

Further details of medical history and recreational activities

N = Normal A = Anormal (please describe)

N	A	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	HEARING	VISION	Color Vision
157	57	23.12	130/80 mmhg	80/mins.	L N R N	DISTANT R L / NEAR R L — Uncorrected / Corrected 6/6 6/6	1. Normal 2. Abnormal

N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A	
√		1. Urinalysis	√		7. Audiogram
√		2. Hb, Blood count, ESR			8. Lung Function
√		3. LFT, RFT, RBS			9. Chest X-Ray
		4. Drug Screen			10. ECG
√		5. Lipids (40 years +)		150/	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.)

ASSESSMENT AND RECOMMENDATIONS:

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

FIT

Date: 05-9-23 Name (Block Capitals): Dr. / Nurse

Signature:

REVIEW/CONSULTATION

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

DR. SHAH FAISAL
General Practitioner
MOH Lic No. 22368

Signature: