

10185

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS



مركز رصيال الصحي
RUSAYL HEALTH CENTRE
NMR, FAHUD, QARNALAY, BMAJA, SAMAWAL, MARJUL

INITIAL EXAMINATION REPORT

Place of examination RS PAC CLINIC BAHJA	Date 03/07/19	DOB: 14/11/1974, CIVIL-2307468, STAFF-10185
Home Telephone number 925 33 892		

If a dependant or fiancee entr employees name jere :-

Surname:

Forenames:

		Nationality OMAN	Country of birth OMAN	Religion ISLAM
<input checked="" type="checkbox"/> Male	<input type="checkbox"/> Single	<input type="checkbox"/> Widow(er)	Relationship to employee	
<input type="checkbox"/> Female	<input checked="" type="checkbox"/> Married	<input type="checkbox"/> Divorced Separated	<input checked="" type="checkbox"/> Wife	<input type="checkbox"/> Son <input checked="" type="checkbox"/> Daughter <input type="checkbox"/> Fiancee
Reason for examination		Pre-employment	Job: - DRIVER	
		Pre-overseas	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 uncertain exclude minor ailmenis.)

	Y	N		Y	N	
1. Sirius trouble		<input checked="" type="checkbox"/>	22. Heart Disease		<input checked="" type="checkbox"/>	42. Awarded benefits for Industrial injury/illness
2. Neck swellings/lands		<input checked="" type="checkbox"/>	23. Rheumatic Fever		<input checked="" type="checkbox"/>	43. Treated for a mental condition. eg. depression
3. Difficulty in vision		<input checked="" type="checkbox"/>	24. Abnormal heartbeat		<input checked="" type="checkbox"/>	44. Treated for problem drinking or drug abuse
4. Any ear discharge		<input checked="" type="checkbox"/>	25. High blood pressure		<input checked="" type="checkbox"/>	45. Exposed to toxic substance or noise
5. Asthma/bronchitis		<input checked="" type="checkbox"/>	26. Stroke		<input checked="" type="checkbox"/>	FOR WOMEN ONLY
6. Hayfever/other allergy		<input checked="" type="checkbox"/>	27. Serious chest pain		<input checked="" type="checkbox"/>	Have you ever 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 /fracture		<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/arm/pil		<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		<input checked="" type="checkbox"/>	

How much tabacco each day? 10-12

Average daily alcohol consuption No

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

Signature of applicant

Date 03/07/19



FOR COMPLETION BY EXAMINING DOCTOR OR SISTER
FURTHER DETAILS OF MEDICAL HISTORY AND RECREATIONAL ACTIVITIES

N - Normal A - Abnormal Please Describe			PHYSICAL EXAMINATION								
N	A										
✓		1. Eyes & Pupils	BMI-34.5kg/m ²								
✓		2. E.N.T.	HR-75b/min								
✓		3. Teeth & Mouth									
✓		4. Lungs & Chest									
✓		5. Cardiovascular System									
✓		6. Abdo. Viscera									
✓		7. Hernial Orifices									
✓		8. Anus & Rectum									
✓		9. Genito - urinary									
✓		10. Extremities									
✓		11. Muscula-skeletal									
✓		12. Skin & Varicose Vns.									
✓		13. C.N.S.									
✓		14. Breasts									
		15.									
HEIGHT cm	WEIGHT kg	B.P.	HEARING L	HEARING R	VISION: Uncorrected	DISTANT R	DISTANT L	NEAR R	NEAR L	COLOUR VISION	BLOOD GROUP
170	98.4	122/95	(A)	(A)		(A)	(A)	(A)	(A)		
			LABORATORY AND SPECIAL INVESTIGATIONS						N	A	
✓	1. Urimalysis		TC- 259 mg/dl								6. Audiogram
✓	2. Hb Bloodcount ESR		HDL- 35-30 mg/dl								7. Lung Function
✓	3. Serum Profile		LDL- 151-22 mg/dl								8. Chest X-Ray
	4. Stool										9. Drug Screen
	5. E.C.G.										10. CR Screen

BMI-34.5kg/m²

OTHER FINDINGS (physique, scars, disabilities, mental stability etc.)



ASSESSMENT

FIT ALL AREAS FIT HOME SERVICES ONLY UNFIT/UNSUITABLE MAY BE REASSESSED

Date 04-07-19

Signature



Doctor / Sister

REVIEW/CONSULTATION

Date

Signature

Name (Block Capitals)

Doctor / Sister