

#10202

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS



مركز الرعاية الصحية  
RUSAYL HEALTH CENTRE  
NIMR, FAHUD, QARNALAM, BHAJA, SAHRIWAL, MARXUL

## INITIAL EXAMINATION REPORT

Surname <b>Jaber Ali Abdullah Al. Yazeedi</b>																																																																																																																																																																							
Forenames <b>DOB. 13-08-82, CN. 4200676</b>																																																																																																																																																																							
Address <b>Truck Oman, Bahja, Haima</b>																																																																																																																																																																							
Place of examination <b>Bahja</b>	Home Telephone number <b>99877185</b>																																																																																																																																																																						
Date <b>6-3-19</b>																																																																																																																																																																							
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<input checked="" type="checkbox"/> Male <input checked="" type="checkbox"/> Single <input type="checkbox"/> Widow(er) <input type="checkbox"/> Female <input type="checkbox"/> Married <input type="checkbox"/> Divorced Separated	Relationship to employee <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Fiancee Number of Children <b>✓</b>																																																																																																																																																																						
Reason for examination <b>POO medicel</b>	Pre-employment Job :- <b>operator</b> Pre-overseas Area:- <b>Haima</b>																																																																																																																																																																						
Name and address of family doctor	List your last 3 jobs																																																																																																																																																																						
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Are you Registered Disabled Person? (UK) <input type="checkbox"/>	Do you belong to any Medical Insurance Scheme? <input type="checkbox"/>																																																																																																																																																																						
DO YOU HAVE OR HAVE YOU HAD :- (Tick 'yes' or 'No' column or put a (?) If uncertain exclude minor ailmenis.)																																																																																																																																																																							
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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.																																																																																																																																																																							
Date <b>6-3-19</b>	Signature of applicant																																																																																																																																																																						

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		<p>Bmi : 24.1 kg/cm<sup>2</sup></p>							
		1. Eyes & Pupils								
		2. E.N.T.								
		3. Teeth & Mouth								
		4. Lungs & Chest								
		5. Cardiovascular System								
		6. Abdo. Viscera								
		7. Hermal 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	HEARING	VISION:	DISTANT	NEAR	COLOUR	BLOOD	
168	68	120/63	L	L	Uncorrected	R	R	VISION	GROUP	
			R	R	Corrected					
N	A	LABORATORY AND SPECIAL INVESTIGATIONS				N	A			
		1. Urinalysis							6. Audiogram	
		2. Hb Bloodcount ESR							7. Lung Function	
		3. Sarum Profile							8. Chest X-Ray	
		4. Stool							9. Drug Screen	
		5. E.C.G.							10. CR Screen	

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

Bmi : Healthy wt.

ASSESSMENT

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

Date 6-3-19

Signature

*[Signature]*

DR. MOHAMMAD MARUF FERDOUS

Name (Block Capitals)

Doctor / Sister

REVIEW/CONSULTATION

Date

Signature

Name (Block Capitals)

Doctor / Sister

