

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE

ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Mobile No. 9688380

Home/Leave Address:

Surname/
Forenames

ISSA MOHD ISSA SULTAN RASHID

Nationality OMANI

Company Number: CIVIL D-21005962

Reference Indicator:

Personal Details

81 years

A Male Female

Married Single Separated /Divorced /Widow(er)

Home/Leave Address:

Relationship to employee

Wife

Son

Daughter

No of Children: 2

Reason for Examination (tick as appropriate)

Periodic Medical Examination

Final / Retirement

Other Reason:

Employee only

B Present Job and Location:

I DD, (RECKOMAN)

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	<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: 12/11/2022

Signature of Applicant:

جعفر

DR. CHIEMERA NDOKA EKEGHE
GENERAL PRACTITIONER
RUSAYL HEALTH CENTRE
MOH LIC NO. 19798



FOR COMPLETION BY EXAMINING DOCTOR OR NURSE

Further details of medical history and recreational activities

N = Normal A = Abnormal (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
✓		11. Musculo-skeletal
✓		12. Skin & Varicose Vns.
✓		13. C.N.S.

HEIGHT cm	WEIGHT kg	BMI	B.P. 136 80	PULSE /mins.	HEARING L (10) R (10)	DISTANT R (6/6) L (6/6)	NEAR R (5/5) L (5/5)	VISION
167	89	31		88	Uncorrected Corrected			

N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A
✓	1. Urinalysis	Lymphocyte - 53.1 MCV - 76.5 MCt - 24.1	✓	7. Audiogram
✓	2. Hb, Bloodcount, ESR	TG - 788 mg/dl ↑ Total Bil - 2.08 ↑		8. Lung Function
✓	3. LFT, RFT, RBS	SGOT - 41.1 ↑ Uric acid - 7.0		9. Chest X-Ray
	4. Drug Screen			10. ECG
	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.)

High Triglycerides.
High Lymphocytes.
Low MCV, MCH.
High Cholinesterase.
Borderline SGOT, urea and
high.

ASSESSMENT AND RECOMMENDATIONS:

FIT ALL AREAS

FIT WITH RESTRICTION

TEMPORARY UNIT

UNEDIT

Date: 18/7/02 Name (Block Capitals): Dr. / Nurse

Signature:

REVIEW/CONSULTATION

Data

Name (Block Capital): D (N)

Signature:





11.20 Appendix 20: (Form SQ5): Epworth Screening Quest. for Sleep Apnoea

Employee Data		Date: 12/06/2022
Name: ISSA MOHAMMED	Department/Company: PDEK OMAN	
ID No. 21005962	Tele: 96883880	Occupation: LDD

This questionnaire will help identify if you have any health condition which may need a more detailed medical assessment as part of your fitness to work determination. If you have any queries please contact your local Health Services staff. All information provided on this form and during consultations remains strictly confidential. When further clinical evaluation is required following completion of a screening questionnaire, the details should be recorded on Q1 and E1 forms.

How likely are you to fall asleep in the following situations? (use 0 to 3 score as shown below)

0 Would never doze

1 Slight chance of dozing

2 Moderate chance of dozing

3 High chance of dozing

sitting and reading

watching TV

sitting inactive in a public place (e.g. theatre or meeting)

as a passenger in the car for an hour without a break

lying down to rest in the afternoon when circumstances permit

sitting a talking with someone

sitting quietly after lunch without alcohol

in a car, while stopped for a few minutes in traffic

Total

1

If you score a total of 15 or more you should seek advice from medical personnel on site before continuing to drive or operate machinery in the workplace.

Declaration: I, ISSA MOHAMMED (Print Name) certify that to the best of my knowledge the above information supplied by me is true and correct.

Signature: DR. CHIEMEKANDUKA EKEGHE

Date: 12/06/2022

Fitness to Work Certificate for Drivers

Employee Data		Date: <u>12/02/2022</u>	
Name: <u>ISMA MOHAMMED ISMA SULTAN</u>	Department/Company: <u>TRUCK OWNER</u>		
I.D. NO: <u>21005969</u>	Age: <u>31</u>	Occupation: <u>EDD</u>	
Type of Medical Evaluation		Mark those applying ✓	
A5- HVD- Crane or forklift driving & all heavy vehicles	<input type="checkbox"/>	A7- Professional driving-light vehicles	<input checked="" type="checkbox"/>
<p>Health Advisor Statement: The above named person has been examined according to the statements laid down in "Protocols and Guidance Notes on the Medical Evaluation of Fitness to Work". At this time his/her fitness to work status for the above tasks is as follows.</p>			
Fit with no restrictions		<input checked="" type="checkbox"/>	
Fit with following restriction(s)		<input checked="" type="checkbox"/>	
The employee is fit for above work but should avoid the following task(s)	Temporary restriction	Permanent restriction	
Work near moving machinery or sharp edges	<input checked="" type="checkbox"/>		
Operate Heavy motor vehicles, forklifts or heavy machinery	<input checked="" type="checkbox"/>		
Other (Specify)			
Temporary Unfit until			
Permanently Unfit			
<div style="border: 1px solid black; padding: 5px; display: inline-block;"> DR. CHIEMEKA NDUKA EKEGHE GENERAL PRACTITIONER RUSAYL HEALTH CENTRE MOH LIC NO. 19798 </div>			
Name of health advisor <u>CHIEMEKA</u>		Signature <u>CHIEMEKA</u>	
		Date <u>18/02/2022</u>	