

10: 11078143



# مركز الرسيل الصحي

## RUSAYL HEALTH CENTRE

ISO 9001 - 2015 Certified Co.

No. B 4826

### ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



#### RUSAYL HEALTH CENTRE

ISO 9001 - 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Surname/Forenames: <b>AL-HASANI ABDUL HAMEED ABDULLAH</b>		Nationality: <b>OMANI</b>	
Mobile No.: <b>97186595</b>	Home/Leave Address:	Company Number: <b>10264</b>	Reference Indicator:
Personal Details: <b>Dob: 27/09/1997 (23 yrs)</b>			
A <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Married <input checked="" type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced /Widow(er)	
Home/Leave Address:		Relationship to employee: <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	No of Children: <b>—</b>
Reason for Examination (tick as appropriate)			
Periodic Medical Examination <input checked="" type="checkbox"/> Final / Retirement <input type="checkbox"/> Other Reason: <input type="checkbox"/>			
Employee only			
B Present Job and Location: <b>HELPER / INTERVIEWER ; TRUCK DRIVER</b>		Next Job and Location:	
Are you a registered person with special needs? <input type="checkbox"/>		Do you belong to any Medical Insurance Scheme? <input type="checkbox"/>	
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?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
1 Ear, nose, eye or throat problems	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
2 Chest problems like asthma, bronchitis, other bad cough	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
3 Heart abnormality, chest pains	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
4 Abdominal pains, abnormal bowel motions	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
5 Urogenital problems (kidney disease, menstrual disorder)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
6 Skin trouble or allergies	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
7 Epileptic fits, dizzy spells or migraine	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
8 History of mental illness, depression anxiety	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
9 Diabetes, thyroid disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
10 Blood disorder e.g. anaemia, blood cancer e.g. leukaemia	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
11 Any history of accidents or fractures	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
12 Have you had any serious allergies	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
13 Do any dependants have a significant ongoing illness?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
14 Any family history of cancers	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Do you take any regular medicines, or have your taken in the past?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Do you smoke? If yes, what and how much each day?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Do you drink alcohol? If yes, what is your average weekly intake?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Have you ever taken elicited/recreational drugs?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Are you doing regular sports or physical activities?	<input checked="" type="checkbox"/>	<input 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: **02/01/2021**

Signature of Applicant:



10. 1107843



# مركز الرسيل الصحي RUSAYL HEALTH CENTRE

ISO 9001- 2015 Certified Co.

AL-HASANEH ABDUL (23 yrs)

No. B 4826

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.	PULSE	HEARING	VISION			
						DISTANT		NEAR	
						R	L	R	L
174.5	108	35.5 kg/m <sup>2</sup>	140/70 mmHg	68 /mins.	L M R M	Uncorrected 6/6	6/6	Uncorrected M	M
						Corrected		Corrected	

  

N		A		LABORATORY AND OTHER SPECIAL INVESTIGATIONS		N		A	
✓				1. Urinalysis					7. Audiogram
✓				2. Hb, Bloodcount, ESR					8. Lung Function
✓				3. LFT, RFT, FBS					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.)

Moderate obesity.

Advised to engage in regular exercise and dietary control.

## ASSESSMENT AND RECOMMENDATIONS:

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

Date: 02/01/2021 Name (Block Capitals): Dr. / Nurse

REVIEW/CONSULTATION

DR. MAGNUS CHIBUZO IWU  
 MEDICAL OFFICER  
 RUSAYL HEALTH CENTRE  
 MOH LIC NO. 17579

Date

Name (Block Capitals) Dr / Nurse

Signature

