

# 1489

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS



رجالی سالم سینا  
RUSAYL HEALTH CENTRE  
NIHR, FAHUD, QARNALAY, BHAJA, SAHRIWAL, MARYUL

## INITIAL EXAMINATION REPORT

Place of examination	Date	1/1	Address	EN - 99436653
Bahrain	24/03/19		Truck farm	
Home Telephone number 974 24834				

If a dependant or fiancee entr employees name jere :-

Surname :

Forenames:

	Nationality	Indian	Country of birth	India	Religion	Others than
<input checked="" type="checkbox"/> Male	<input type="checkbox"/> Single	<input type="checkbox"/> Widower	<input type="checkbox"/> Wife	<input checked="" type="checkbox"/> Son	<input checked="" type="checkbox"/> Daughter	<input type="checkbox"/> Fiancee
<input type="checkbox"/> Female	<input checked="" type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Separated			Number of Children

Reason for examination	<input type="checkbox"/> Pre-employment	Job :-	mechanic
<input checked="" type="checkbox"/> Pre-medical	<input type="checkbox"/> Pre-overseas	Area:-	Latima

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 ailments.)

	Y	N		Y	N		Y	N
1. Sirius trouble			22. Heart Disease			42. Awarded benefits for Industrial injury/illness		
2. Neck swellings/flands			23. Rheumatic Fever			43. Treated for a mental condition, eg. depression		
3. Difficulty in vision			24. Abnormal heartbeat			44. Treated for problem drinking or drug abuse		
4. Any ear discharge			25. High blood pressure			45. Exposed to toxic substance or noise		
5. Asthma/bronchitis			26. Stroke			FOR WOMEN ONLY		
6. Hayfever/other allergy			27. Serious chest pain			Have you ever had:-		
7. Any skin trouble			28. Any blood disease			46. An abnormal smear		
8. Tuberculosis			29. Kidney disease			47. Any gynaecological treatment		
9. Shortness of breath			30. Painful passage of urine			48. Are you pregnant?		
10. Coughed/vomited blood			31. Blood in urine			49. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE ?		
11. Severe abdominal pain			32. Diabetes					
12. Stomach ulcer			33. Headaches /migraine					
13. Recurrent indigestion			34. Dizziness/tainting					
14. Jaundice or hepatitis			35. Epilepsy					
15. Gall bladder disease			36. Joints/spinal trouble					
16. Marked change in bowel habits			37. Surgical operation					
17. Blood in stools (motions)			38. Serious accident /fracture					
18. Marked change in weight			39. Tropical disease					
19. Varicose veins			40. Fear of heights					
20. Lump in breast/armpit			HAVE YOU EVER BEEN:-					
21. Cancer			41. Rejected for employment or insurance for medical reasons					

How much tabacco each day ?

N/A

Average daily alcohol consuption

N/A

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

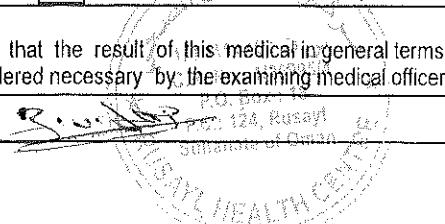
PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT :-

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.

Date

24/03/19

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>B.M.L. 2604 KG. CM. 2</p>									
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. Muscula-skeletal 12. Skin & Varicose Vns. 13. C.N.S. 14. Breasts 15.											
HEIGHT cm	WEIGHT kg	B.P. 134/80	HEARING L R	HEARING L R	VISION: Uncorrected Corrected	DISTANT R L	NEAR R L	COLOUR VISION O	BLOOD GROUP		
189	84										
N A		LABORATORY AND SPECIAL INVESTIGATIONS					N	A			
1. Urimalysis 2. Hb Bloodcount ESR 3. Sarum Profile 4. Stool 5. E.C.G.									6. Audiogram 7. Lung Function 8. Chest X-Ray 9. Drug Screen 10. CR Screen		

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

B.M.L. Healthy etc.

ASSESSMENT

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

Date 25-3-19

Signature

DR. MOHAMMAD MARUF PERDOUS  
Name (Block Capitals)  
MEDICAL OFFICER  
RUSAYL HEALTH CENTRE  
MOH LIC NO. 12930

Doctor / Sister

REVIEW/CONSULTATION

Date

Signature

Name (Block Capitals)

