



# مركز الرسيل الصحي RUSAYL HEALTH CENTRE

ISO 9001 - 2015 Certified Co.

#1628

No. B 05492

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



**RUSAYL HEALTH CENTRE**  
ISO 9001 - 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL  
DETAILS IN BLOCK CAPITALS

Surname/  
Forenames

ILYAS MUSSATIN

Nationality

PAKISTANI (ID NO: 108826671)

Mobile No. 99553196

Home/Leave Address:

TRUCK CAMP

Company Number:

Reference Indicator:

Personal Details

DOB: 29/02/83

AGE: 37 YRS

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:

OWN ROOM

Next Job and Location:

HOOD

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			
2 Chest problems like asthma, bronchitis, other bad cough			
3 Heart abnormality, chest pains			
4 Abdominal pains, abnormal bowel motions			
5 Urogenital problems (kidney disease, menstrual disorder)			
6 Skin trouble or allergies			
7 Epileptic fits, dizzy spells or migraine			
8 History of mental illness, depression anxiety			
9 Diabetes, thyroid disease			
10 Blood disorder e.g. anaemia, blood cancer e.g. leukaemia			
11 Any history of accidents or fractures			
12 Have you had any serious allergies			
13 Do any dependants have a significant ongoing illness?			
14 Any family history of cancers			
Do you take any regular medicines, or have you taken in the past?			
Do you smoke? If yes, what and how much each day?			
Do you drink alcohol? If yes, what is your average weekly intake?			
Have you ever taken elicited/recreational drugs?			
Are you doing regular sports or physical activities?			

**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:

16/9/21

Signature of Applicant:

*[Signature]*



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FOR COMPLETION BY EXAMINING DOCTOR OR NURSE

Further details of medical history and recreational activities

N = Normal A = Abnormal (please describe)

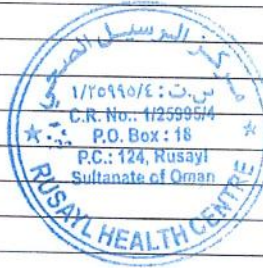
## PHYSICAL EXAMINATION

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			
182	88	26.4	130/90	79/min.	L (N) R (N)	DISTANT		NEAR	
						R	L	R	L
						Uncorrected	6/6	6/6	N
						Corrected			N

C5/mix vision (N)



N	A		LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A	
/		1. Urinalysis	<p>888 = 98mg/dl</p> <p>↑ Total Cholesterol</p> <p>↑ TGPT</p>			7. Audiogram
/		2. Hb, Bloodcount, ESR				8. Lung Function
/		3. LFT, RFT, RBS				9. Chest X-Ray
		4. Drug Screen				10. ECG
/		5. Lipids (40 years +)				11. CVS risk for 40 yrs. & above
		6. Sickie Cell test				12. HIV, Hepatitis screening

OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)

*Dietary & lifestyle changes advised to start 2 days after review on 3/12*

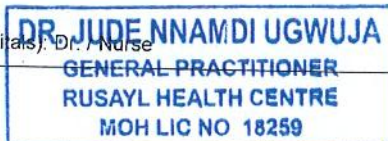
ASSESSMENT AND RECOMMENDATIONS:

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

Date: 16/12/21 Name (Block Capitals): Dr. / Nurse

Signature:

REVIEW/CONSULTATION



Date: Name (Block Capitals): Dr. / Nurse

Signature: