

1628

TRUCK OMAN



# Appendix 33: EX2 Form (Routine/Periodic Medical Examination)

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

nt 16102 Reg.Dt 26/01/2023  
ILYAS HUSSAIN  
er Male Nationality PAKISTANI

Development Oman  
AL DEPARTMENT

Surname/  
Forenames ILYAS HUSSAIN

Nationality PAKISTANI DOB - 23/02/198.

PLEASE COMPLETE YOUR PERSONAL  
DETAILS IN BLOCK CAPITALS

Mobile No. 93353196 Address: 108826671  
Company Number: Reference Indicator:

### Personal Details

A ☒ Male ☐ Female ☒ Married ☐ Single ☐ Separated /Divorced /Widow(er)

Home/Leave Address: Relationship to employee  
☐ Wife ☐ Son ☐ Daughter No of Children: 3

Reason for Examination (tick as appropriate)

Periodic Medical Examination ☒ Final / Retirement ☐ Other Reason: ☐

### Employee only

B Present Job and Location: HEAVY DRIVER 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?	<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, another 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, history of Hypertension	<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 type="checkbox"/>	<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: 26/01/2023

Signature of Applicant:



*[Signature]*



Appendix 33: EX2 Form (Routine/Periodic Medical Examination)  
**ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL –  
CONFIDENTIAL)**

FOR COMPLETION BY EXAMINING DOCTOR OR NURSE

Further details of medical history and recreational activities

N = Normal A = Anormal (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	Color Vision
174	76	25.1	120/80 mmhg	67 /mins.	L N R N	DISTANT R L Uncorrected 6/6 6/6 Corrected	1. Normal 2. Abnormal
N	A						
✓		1. Urinalysis				✓	7. Audiogram
✓		2. Hb, Blood count, ESR					8. Lung Function
✓		3. LFT, RFT, RBS					9. Chest X-Ray
		4. Drug Screen				✓	10. ECG
	✓	5. Lipids (40 years +)				4.2%	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 Lipids profile repeat after 3 months & life modification

**ASSESSMENT AND RECOMMENDATIONS:**

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

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

Signature: \_\_\_\_\_  
DR. FARZAD FARHAD ABBASMANESH  
GENERAL PRACTITIONER  
M.O.H LICENSE NO. 20379

REVIEW/CONSULTATION

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

Signature: \_\_\_\_\_