

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS



ریاضی سعیل
RUSAYL HEALTH CENTRE
NMR, FAHUD, QARNALAM, BHAJA, SAHRIWAL, MARWAL

INITIAL EXAMINATION REPORT

Place of examination Bhaja	Date 25-3-19	Surname Ratheesh chakkaran chandran		
Forenames DOB. 16-08-84				
Address EN - 100283113				
Truck - Oman p. Naima				
Home Telephone number 99783713				

If a dependant or fiancee entr employees name jere :-

Surname:

Forenames:

	Nationality Indian	Country of birth India	Religion Hindu
<input checked="" type="checkbox"/> Male	<input type="checkbox"/> Single	<input type="checkbox"/> Widow(er)	Relationship to employee
<input type="checkbox"/> Female	<input checked="" type="checkbox"/> Married	<input type="checkbox"/> Divorced Separated	<input type="checkbox"/> Wife <input checked="" type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Fiancee
Number of Children 2			

Reason for examination Poo medical	Pre-employment	Job :- DOZ WER
	Pre-overseas	Area:- Haima

Name and address of family doctor	List your last 3 jobs
	(1)
	(2)
	(3)

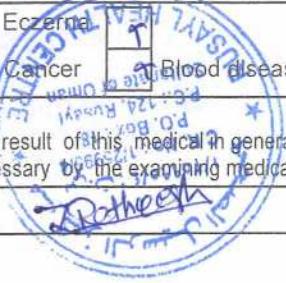
Are you Registered Disabled Person? (UK)	<input type="checkbox"/>	Do you belong to any Medical Insurance Scheme?	<input type="checkbox"/>
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DO YOU HAVE OR HAVE YOU HAD :- (Tick "yes" or "No" column or put a (?) It unclain exclude minor ailmenis.)

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

How much tabacco each day ? **NA** Average daily alcohol consuption **social drinker**

Family history	<input checked="" type="checkbox"/> Diabetes	<input checked="" type="checkbox"/> Tuberculosis	<input checked="" type="checkbox"/> Epilepsy	<input checked="" type="checkbox"/> Asthma	<input checked="" type="checkbox"/> Eczema
	<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"/> Blood disease

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 **25-03-19** Signature of applicant **Ratheesh**

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	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. mm Hg.	HEARING L	HEARING R	VISION: Uncorrected Corrected	DISTANT R L	NEAR R L	COLOUR VISION	BLOOD GROUP	
172	91	119/80 mm Hg.	0	0		0	+	0		
			LABORATORY AND SPECIAL INVESTIGATIONS				N	A		
1. Urimalysis									6. Audiogram	
2. Hb Bloodcount ESR									7. Lung Function	
3. Sarum Profile									8. Chest X-Ray	
4. Stool									9. Drug Screen	
5. E.C.G.									10. CR Screen	

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

BMI : obese

ASSESSMENT

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

Date 26-03-19 Signature

DR. MOHAMMAD MARUF FERDOUS

Name (Block Capitals) OFFICER
RUSAYL HEALTH CENTRE
MOH LIC NO. 12930

Doctor / Sister

REVIEW/CONSULTATION

Date

Signature

Name (Block Capitals)

