

1633

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS



رجال الرسیل الطبی
RUSAYL HEALTH CENTRE
NMR, FAHUD, QARNALAY, BHAJA, SAHRIWAL, MARJUL

INITIAL EXAMINATION REPORT

Place of examination

Date 02/07/19

RS PAC CLINIC BAHJA

Surname ABDAS	
Forenames ALT	
Address TRNUKOTMAN	
DOB: 23/03/1989, CIVL-108911429, STAFF108911	
Home Telephone number 94015867	

If a dependant or fiancee entr employees name jere :-

Surname :

Forenames:

		Nationality PAKISTAN	Country of birth PAKISTAN	Religion ISLAM
<input checked="" type="checkbox"/> Male	<input type="checkbox"/> Single	<input checked="" type="checkbox"/> Widow(er)	Relationship to employee	
<input checked="" type="checkbox"/> Female	<input checked="" type="checkbox"/> Married	<input checked="" type="checkbox"/> Divorced Separated	<input checked="" type="checkbox"/> Wife	<input checked="" type="checkbox"/> Son <input checked="" type="checkbox"/> Daughter <input checked="" type="checkbox"/> Fiancee
Number of Children 1				

Reason for examination Pre-employmentJob :- **DRIVER (HEAVY)** Pre-overseasArea:- **BAHJA**

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 (?) It uncertain exclude minor ailmenis.)

Y	N	Y	N	Y	N
1. Sirius rouble	<input checked="" type="checkbox"/>	22. Heart Disease	<input checked="" type="checkbox"/>	42. Awarded benifites for Industrial injury/lilness	<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	
6. Hayfever/other allergy	<input checked="" type="checkbox"/>	27. Serious chest pain	<input checked="" type="checkbox"/>	Have you ever had:-	
7. Any skin trouble	<input checked="" type="checkbox"/>	28. Any blood disease	<input checked="" type="checkbox"/>	46. An abnormal smear	
8. Tuberculosis	<input checked="" type="checkbox"/>	29. Kidney disease	<input checked="" type="checkbox"/>	47. Any gynaecological treatment	
9. Shortness of breath	<input checked="" type="checkbox"/>	30. Painful passage of urine	<input checked="" type="checkbox"/>	48. Are you pregnant?	
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 ?	
11. Severe abdominal pain	<input checked="" type="checkbox"/>	32. Diabetes	<input checked="" type="checkbox"/>		
12. Stomach ulcer	<input checked="" type="checkbox"/>	33. Headaches /migraine	<input checked="" type="checkbox"/>		
13. Recurrent indigestion	<input checked="" type="checkbox"/>	34. Dizziness/tainting	<input checked="" type="checkbox"/>		
14. Jaundice or hepatitis	<input checked="" type="checkbox"/>	35. Epilepsy	<input checked="" type="checkbox"/>		
15. Gall bladder disease	<input checked="" type="checkbox"/>	36. Joints/spinal trouble	<input checked="" type="checkbox"/>		
16. Marked change in bowel habits	<input checked="" type="checkbox"/>	37. Surgical operation	<input checked="" type="checkbox"/>		
17. Blood in stools (motions)	<input checked="" type="checkbox"/>	38. Serious accident /fracture	<input checked="" type="checkbox"/>		
18. Marked change in weight	<input checked="" type="checkbox"/>	39. Tropical disease	<input checked="" type="checkbox"/>		
19. Varicose veins	<input checked="" type="checkbox"/>	40. Fear of heights	<input checked="" type="checkbox"/>		
20. Lump in breast/armpit	<input checked="" type="checkbox"/>	HAVE YOU EVER BEEN:-			
21. Cancer	<input checked="" type="checkbox"/>	41. Rejected for employment or insurance for medical reasons	<input checked="" type="checkbox"/>		

How much tabacco each day ? **Non-smoker**Average daily alcohol consupton **No**

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 **02-07-19**Signature of applicant **ABDAS**

Fitness to Work Certificate for drivers

Employee Data		Date: 02-07-19	
Name: ALE ABBAS		Department/Company: TRUCKMAN	
ID No: 108911429	Age: 31Y	Occupation: DRIVER	
Type of Medical Evaluation		Mark those applying	
A5- HWD- Crane or forklift driving & all heavy vehicles		<input checked="" type="checkbox"/> A7- Professional driving-light vehicles	
<p>Health Advisor Statement: The above named person has been examined according to the statements laid down in "Protocols and Guidance Notes on the Medical Evaluation of Fitness to Work". At this time his/her fitness to work status for the above tasks is as follows:</p>			
Fit with no restrictions		✓	
Fit with following restriction(s)			
The employee is fit for above work but should avoid the following task(s)		Temporary restriction	Permanent restriction
Work near moving machinery or sharp edges			
Operate Heavy motor vehicles, forklifts or heavy machinery			
Other (Specify)			
Temporary Until			
Permanently Until			
Dr. Hasan		Signature	
Name of health advisor		Date	

DR. HASAN MAHBUB KHAN BAYZID
 MEDICAL OFFICER
 RUSAYL HEALTH CENTRE
 MOH LIC NO. 15691

