

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE
ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

RHC RUSAYL HEALTH CENTRE ISO 9001- 2015 Certified Co.		Surname/ Forenames ALI NAZAKAT
Personal Details Mobile No. 99837120		Nationality PAKISTAN (CIN No: 108992202)
Home/Leave Address: Truck OMAN		Company Number: Reference Indicator:
A <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		<input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced /Widow(er)
Home/Leave Address: Relationship to employee		<input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter
Reason for Examination (tick as appropriate)		
<input checked="" type="checkbox"/> Periodic Medical Examination <input type="checkbox"/> Final / Retirement <input type="checkbox"/> Other Reason:		
Employee only		
B Present Job and Location: Oman Alim		Next Job and Location: KDD
Are you a registered person with special needs? <input type="checkbox"/>		Do you belong to any Medical Insurance Scheme? <input type="checkbox"/>
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
Have you, since your last medical been treated by your family doctor or specialist for significant (major) ailments?		<input checked="" type="checkbox"/>
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:	Signature of Applicant:	

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. 130/ 90	PULSE 68 /mins.	HEARING L (A) R	VISION	
						DISTANT R L	NEAR R L
166.5	78	26.3			Uncorrected Corrected	6/6 6/6	N/N

N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A
		1. Urinalysis		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. Sickle Cell test		12. HIV, Hepatitis screening

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

Dietary & lifestyle changes i favor of review in 3/12

ASSESSMENT AND RECOMMENDATIONS:

FIT ALL AREAS FIT WITH RESTRICTION TEMPORARY UNFIT UNFIT

Date: 24/09/20

Name (Block Capitals): Dr. / Nurse
DR. JUDE NNAMDI UGWUJA
GENERAL PRACTITIONER
RUSAYL HEALTH CENTRE
MOH LIC NO 18259

Signature: 

REVIEW/CONSULTATION

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

Fitness to Work Certificate for Drivers

Employee Data		Date: 24-SEPTEMBER-2020	
Name: ALI NAZAKAT		Department/Company: TRUCK OMAN	
I.D No. 108992208	Age: 32	Occupation: HDD	
Type of Medical Evaluation		Mark those applying ✓	
A5 HVD- Crane or forklift driving & all heavy vehicles		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/light motor vehicles, forklifts or heavy machinery			
Other (Specify)			
Temporary Unfit until			
Permanently Unfit		Date	
Name of Health Advisor		Signature	Date
		24-SEPTEMBER-2020	

DR. JUDE NNAMDI UGWUJA
GENERAL PRACTITIONER
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