

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)

RUSAYL HEALTH CENTRE
ISO 9001- 2015 Certified Co.
 PLEASE COMPLETE YOUR PERSONAL
 DETAILS IN BLOCK CAPITALS

Surname/
Foronames:

Yoko Sanchez

Nationality:

Rerum Expedita Aliqu

Mobile No. 34	Home/Leave Address: Ex Culpa Odio Vero	Company Number: 391	Reference Indicator: Et Numquam Temporibu
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Personal Details

A Male Female

Married Single Separated /Divorced

Home/Leave Address: Ex Culpa Odio Vero

Relationship To Employee
 Wife Son Daughter

No Of Children: 546

Reason For Examination (tick As Appropriate)

Periodic Medical Examination Final / Retirement Other Réason

Employee Only

B Present Job And Location: Velit Eos Dolores Q

Next Job And Location: Next Job 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 type="checkbox"/>	<input checked="" type="checkbox"/>	Ad Obcaecati Magni I
Ear, Nose, Eye Or Throat Problems	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Adipiscing In Animi
Chest Problems Like Asthma, Bronchitis, Other Bad Cough	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Non Quo Odio Autem I
Heart Abnormality, Chest Pains	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Qui Ea Minima Est Ut
Abdominal Pains, Abnormal Bowel Motions	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Pariatur Et Amet F
Urogenital Problems (kidney Disease, Menstrual Disorder)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Nihil Et Sed Consequ
Skin Trouble Or Allergies	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Minima Incidunt Rem
Epileptic Fits, Dizzy Spells Or Migraine	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Tempore Eos Quas As
History Of Mental Illness, Depression Anxiety	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Nostrud Vel Tempore
Diabetes, Thyroid Disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Culpa Quia Doloremq
Blood Disorder E.G. Anaemia, Blood Cancer E.G. Leukaemia	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Corporis Eos Ex Vel
Any History Of Accidents Or Fractures	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Modi Quia Quae Hic D
Have You Had Any Serious Allergies	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Officiis Iste Qui Of
Any Family History Of Cancers	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Sed Occaecat Laudant
Do You Take Any Regular Medicines, Or Have Your Taken In The Past	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Dicta Magnam Dolor M
Do You Smoke? If Yes, What And How Much Each Day?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Eos Maiores Quisqua
Do You Drink Alcohol? If Yes, What Is Your Average Weekly Intake?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Omnis Aliquam Incidi
Have You Ever Taken Elicited/recreational Drugs?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Nihil Quis Sit Quae
Are You Doing Regular Sports Or Physical Activities?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Illum Quis Aut Ex I

STATEMENT: | 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. . | 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 :