

**Initial Medical Examination Report**  
**INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)**

Place of examination: Aster Hospital, Ibri Date: 03/02/21

Surname: *YANUS*  
Forenames: *Yous Yonus Salim mukhtar*  
Address: *Ibri*  
Home telephone number: *96 38 11 33*

If a dependant enter employee's name here:

Birth date: <i>20/01/1980</i>	Nationality: <i>Indias</i>	Country of birth: <i>Indias</i>	Religion:
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced	<input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	Relationship to employee
			Number of children: <i>3</i>

Reason for examination Pre-Employment  Job:

Pre-Overseas  Area:

Name and address of family doctor List your last 3 jobs

(1)

Are you a Registered Disabled Person? (UK only)  Do you belong to any Medical Insurance Scheme?

DO YOU HAVE OR HAVE YOU HAD:- (Tick "Yes" or "No" column or put a (?) if uncertain exclude minor ailments.)

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

How much tobacco each day?

Average daily alcohol consumption

Have you ever taken elicited drugs? ( ) PDO test all new/potential employees for elicited/recreational drugs

FAMILY HISTORY: Diabetes ( ) Tuberculosis ( ) Epilepsy ( ) Asthma ( ) Eczema ( )  
Heart disease ( ) High blood pressure ( ) Stroke ( ) Blood Disease ( ) Cancer ( )

**PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT:-**

I declared these statements to be true to the best of my knowledge and belief and I agree that the result of this medical examination 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. I am also aware that PDO reserve the right to dismiss me if it was found that I have purposely withheld important medical information.

Date: 03/02/2021

Signature of Applicant: *BS*

**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																																
<input checked="" type="checkbox"/>	1. Eyes & Pupils																																
<input checked="" type="checkbox"/>	2. E.N.T.																																
<input checked="" type="checkbox"/>	3. Teeth & Mouth																																
<input checked="" type="checkbox"/>	4. Lungs & Chest																																
<input checked="" type="checkbox"/>	5. Cardiovascular System																																
<input checked="" type="checkbox"/>	6. Abdo. Viscera																																
<input checked="" type="checkbox"/>	7. Hernial Orifices																																
<input checked="" type="checkbox"/>	8. Anus & Rectum																																
<input checked="" type="checkbox"/>	9. Genito-urinary																																
<input checked="" type="checkbox"/>	10. Extremities																																
<input checked="" type="checkbox"/>	11. Musculo-skeletal																																
<input checked="" type="checkbox"/>	12. Skin & Varicose Vns.																																
	13. C.N.S.																																
HEIGHT cm		WEIGHT kg	BMI	B.P. 120 80 mmHg	PULSE /mins. 80bpm	HEARING L R	VISION					Colour Vision	Blood Group																				
171 cm		73kg	25.0				DISTANT		NEAR																								
							R	L	R	L																							
							Uncorrected		6/9 6/9 6/9 6/6																								
							Corrected		6/9 6/9 6/9 6/6																								
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS					N	A																									
<input checked="" type="checkbox"/>	1. Urinalysis						<input checked="" type="checkbox"/>	7. Audiogram																									
<input checked="" type="checkbox"/>	2. Hb, Bloodcount, ESR											<input checked="" type="checkbox"/>	8. Lung Function																				
<input checked="" type="checkbox"/>	3. LFT, RFT, RB8																<input checked="" type="checkbox"/>	9. Chest X-Ray															
	4. Drug Screen																					<input checked="" type="checkbox"/>	10. ECG										
<input checked="" type="checkbox"/>	5. Lipids (40 years +)																										<input checked="" type="checkbox"/>	11. CVS risk for 40 yrs. & above					
<input checked="" type="checkbox"/>	6. Sickle Cell test																															<input checked="" type="checkbox"/>	12. HIV, Hepatitis screening

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

**ASSESSMENT:**

FIT ALL AREAS

FIT WITH RESTRICTION

TEMPORARY UNFIT

UNFIT

Advice : FBS, Fasting lipid profile  
after one Month  
Medication

3/02/2021  
Date:

DR. RAGINI  
Name (Block Capitals): Dr.



**REVIEW/CONSULTATION**

Date:

Name (Block Capitals): Dr.

Signature:

DEPARTMENT OF LABORATORY MEDICINE

<b>File No:</b> 183596	<b>Report No:</b> 0563971		
<b>Name:</b> YONUS SALIM MUDERI	<b>Sample Date:</b> 03/02/2021	<b>Time:</b> 12:10	
<b>Address:</b>	<b>Received By:</b> ASHWINI		
<b>Gender:</b> M <b>Age:</b> 51 Y <b>Nationality:</b> INDIAN	<b>Received Date:</b> 03/02/2021	<b>Time:</b> 12:14	
<b>GSM No.:</b> 94381133 <b>ID Card No.:</b> 116159485	<b>Report Date:</b> 03/02/2021	<b>Time:</b> 12:49	
<b>Ref. By:</b> EXTERNAL DOCTOR	<b>Bill No:</b> 0744896	<b>Bill Date:</b> 03/02/2021	
	<b>Report Status:</b> Final		

INVESTIGATION	RESULT	REFERENCE RANGE
PDO MEDICAL CHECK UP ABOVE 40( truckoman)		
RBS (RANDOM BLOOD SUGAR)	12.82 mmol/L	3.9 - 7.8
Method :- Hexokinase	230.76 mg/dL	70 - 140
LIPID PROFILE - SERUM		
CHOLESTEROL (TOTAL)	9.05 mmol/L	1 - 5.1
Method:-Enzymatic	349.87 mg/dl	40 - 200
HDL (HIGH DENSITY LIPOPROTEIN)	1.39 mmol/L	0.777 - 1.813
" "	53.50 mg/dl	30 - 70
LDL (LOW DENSITY LIPOPROTEIN)	4.39 mmol/L	1.295 - 4.54
" "	169.64	50 - 172
VLDL (VERY LOW DENSITY LIPOPROTEIN)	3.28 mmol/L	0.259 - 1.036
" "	126.73 mg/dl	10 - 40
RATIO (TOTAL CHOL / HDL CHOL)	6.51	3.8 - 5.9
TRIGLYCERIDES	7.16 mmol/L	0.564 - 2.146
Method : Enzymatic	633.66 mg/dl	50 - 190
LIVER FUNCTION TEST - SERUM		
TOTAL BILIRUBIN - SERUM	0.54 mg/dL	0.1 - 1
Method : Diazo	9.30 µmol/L	1 - 17.1
DIRECT BILIRUBIN - SERUM	0.17 mg/dL	0.1 - 0.5
Method : Diazo	2.92 µmol/L	1 - 8.55
SGOT (AST)-SERUM (IFCC)	18.70 U/L	Male: up to 40.0 Female: up to 32.0
SGPT (ALT)-SERUM (IFCC)	22.40 U/L	Male: 10-50 Female: 10-35
ALKALINE PHOSPHATASE (ALP)-SERUM (IFCC)	96.18 U/L	Adult : Men -40-129

Processed By:  
SWATHY  
Lab Technologist

Approved By:  
ASHWINI  
Lab Technologist

Released By:  
ASHWINI  
Lab Technologist

Specialist Pathologist

MOH License No: 13250

MOH License No: 16064

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