

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

Place of examination: Aster Hospital,Ibri		Surname <i>Qaiser Ali</i>																																																																																																																												
Date: <i>4,2-2021</i>		Forenames																																																																																																																												
		Address:																																																																																																																												
If a dependant enter employee's name here:																																																																																																																														
Birth date: <i>6.10.1985</i>		Project: <i>Pakistan</i>																																																																																																																												
Nationality: <i>Pakistan</i>		Country of birth: <i>Pakistan</i>																																																																																																																												
<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced																																																																																																																												
		<input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter																																																																																																																												
Reason for examination		Relationship to employee																																																																																																																												
Pre-Employment		<input type="checkbox"/> Job:																																																																																																																												
Pre-Overseas		<input type="checkbox"/> Area:																																																																																																																												
Name and address of family doctor		List your last 3 jobs (1)																																																																																																																												
Are you a Registered Disabled Person? (UK only) <input type="checkbox"/>		Do you belong to any Medical Insurance Scheme? <input type="checkbox"/>																																																																																																																												
DO YOU HAVE OR HAVE YOU HAD:- (Tick "Yes" or "No" column or put a (?) if uncertain exclude minor ailments.)																																																																																																																														
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How much tobacco each day? <i>NO</i>		Average daily alcohol consumption <i>NO</i>																																																																																																																												
Have you ever taken elicited drugs? () PDO test all new/potential employees for elicited/recreational drugs																																																																																																																														
FAMILY HISTORY: Diabetes () <i>NO</i> Tuberculosis () <i>NO</i> Epilepsy () <i>NO</i> Asthma () <i>NO</i> Eczema () <i>NO</i> Heart disease () <i>NO</i> High blood pressure () <i>NO</i> Stroke () <i>NO</i> Blood Disease () <i>NO</i> Cancer () <i>NO</i>																																																																																																																														
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: <i>4/2/2021</i>		Signature of Applicant: <i>[Signature]</i>																																																																																																																												

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.																		
<input checked="" type="checkbox"/>	13. C.N.S.																		
HEIGHT 170 cm		WEIGHT 78kg	BMI 27.0	B.P. 134/70 mmHg	PULSE 70 mins.	HEARING L R	VISION					Colour Vision	Blood Group						
									DISTANT	NEAR									
								R	L	R	L								
							Uncorrected	6/6 6/6											
							Corrected												
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS					N	A											
<input checked="" type="checkbox"/>	1. Urinalysis	<i>1 Tn for covid, VLDL</i>							7. Audiogram										
<input checked="" type="checkbox"/>	2. Hb, Bloodcount, ESR								8. Lung Function										
<input checked="" type="checkbox"/>	3. LFT, RFT, RBS													9. Chest X-Ray					
<input checked="" type="checkbox"/>	4. Drug Screen														10. ECG				
<input checked="" type="checkbox"/>	5. Lipids (40 years +)														11. CVS risk for 40 yrs. & above				
<input checked="" type="checkbox"/>	6. Sickle Cell test														12. HIV, Hepatitis screening				
OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.) <i>Advised diet and exercise to recheck lipid profile after 2 months</i>																			
ASSESSMENT: <input checked="" type="checkbox"/> FIT ALL AREAS <input type="checkbox"/> FIT WITH RESTRICTION <input type="checkbox"/> TEMPORARY UNFIT <input type="checkbox"/> UNFIT																			
Date: 4/11/2021		Name (Block Capitals): Dr. RAKESH YELLA Signature: 																	
REVIEW/CONSULTATION																			
Date: 4/11/2021		Name (Block Capitals): Dr. Signature: 																	

Oman Al Khair Hospital LLC

P.O. Box 400, P.C. : 511, Ibri, Sultanate of Oman
Tel: + 968 2568 8075, Fax: +968 2568 8025
Email :oakh.ibri@asterhospital.com
www.asterhospital.com
A Unit of DM Healthcare LLC

مستشفى عمان الخير م.م.ش

ص.ب. ٤٠٠ الرمز البريدي ٥١١، عبّر، سلطنة عمان
هاتف: +٩٦٨ ٢٥٦٨٨٠٧٥ فاكس: +٩٦٨ ٢٥٦٨٨٠٥٥
البريد الإلكتروني: oakh.ibri@asterhospital.com www.asterhospital.com
وحدة من مجموعة د.موبيان للرعاية الصحية

DEPARTMENT OF LABORATORY MEDICINE

File No:	0184349	Report No:	0564069
Name:	QAISER ALI	Sample Date:	04/02/2021 Time: 12:40
Address:		Received By:	ASHWINI
Gender:	M Age: 36 Y	Received Date:	04/02/2021 Time: 12:45
Nationality:	PAKISTANI	Report Date:	04/02/2021 Time: 13:58
GSM No.:	79087640	Bill No:	0745024 Bill Date: 04/02/2021
ID Card No.:	116237514	Report Status:	Final
Ref. By:	EXTERNAL DOCTOR		

INVESTIGATION	RESULT	REFERENCE RANGE
PDO MEDICAL CHECK UP BELOW 40 (Truckoman)		
FBS (FASTING BLOOD SUGAR)	5.61 mmol/L	3.9 - 6.1
Method :- Hexokinase	100.98 mg/dL	70 - 110
LIPID PROFILE - SERUM		
CHOLESTEROL (TOTAL)	4.61 mmol/L	1 - 5.1
Method:-Enzymatic	178.22 mg/dl	40 - 200
HDL (HIGH DENSITY LIPOPROTEIN)	0.98 mmol/L	0.777 - 1.813
" "	38.0 mg/dl	30 - 70
LDL (LOW DENSITY LIPOPROTEIN)	2.26 mmol/L	1.295 - 4.54
" "	87.3	50 - 172
VLDL (VERY LOW DENSITY LIPOPROTEIN)	1.37 mmol/L	0.259 - 1.036
" "	52.92 mg/dl	10 - 40
RATIO (TOTAL CHOL / HDL CHOL)	4.7	3.8 - 5.9
TRIGLYCERIDES	2.99 mmol/L	0.564 - 2.146
Method : Enzymatic	264.615 mg/dl	50 - 190
LIVER FUNCTION TEST - SERUM		
TOTAL BILIRUBIN - SERUM	0.29 mg/dL	0.1 - 1
Method : Diazo	5.00 µmol/L	1 - 17.1
DIRECT BILIRUBIN - SERUM	0.15 mg/dL	0.1 - 0.5
Method : Diazo	2.59 µmol/L	1 - 8.55
SGOT (AST)-SERUM (IFCC)	27.80 U/L	Male: up to 40.0 Female: up to 32.0
SGPT (ALT)-SERUM (IFCC)	42.20 U/L	Male: 10-50 Female: 10-35
ALKALINE PHOSPHATASE (ALP)-SERUM (IFCC)	102.79 U/L	Adult : Men -40-129

[Signature]
Processed By:
ASHWINI
Lab Technologist

[Signature]
Approved By:
ASHWINI
Lab Technologist

[Signature]
ASHWINI
MEDICAL
LABORATORY
Released By:
AST
MOH
ASHWINI
Lab Technologist

Specialist Pathologist

MOH License No: 16064

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Printed at: 04/02/2021 1:58:30 PM

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وحدة من مجموعة دموين للرعاية الصحية