

Initial Medical Examination Report

INITIAL EXAMINATION REPORT (MEDICAL - CONFIDENTIAL)

Place of examination: Aster Hospital, Ibri		Surname <i>Amer Sohai</i>																																																																													
Date: <i>01/02/2021</i>		Forenames <i>Muhammad</i>																																																																													
Address:																																																																															
Home telephone number																																																																															
If a dependant enter employee's name here:		Project:																																																																													
Birth date: <i>16/04/1995</i>		Nationality: <i>Pakistan</i>																																																																													
Male <input checked="" type="checkbox"/> Female <input type="checkbox"/>		Country of birth: _____																																																																													
Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced <input type="checkbox"/>		Relationship to employee Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/>																																																																													
Number of children: _____																																																																															
Reason for examination 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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Diabetes</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>32. Headaches/migraine</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>33. Dizziness/fainting</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>34. Epilepsy</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>35. Joints/spinal trouble</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>36. Surgical operation</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>37. Serious accident/fracture</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>38. Tropical disease</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>39. Fear of heights</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>40. Rejected for employment or insurance for medical reasons</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>41. Awarded benefits for industrial injury/illness</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>42. 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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 <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"/> Blood Disease <input checked="" type="checkbox"/> Cancer <input checked="" type="checkbox"/>																																																																															
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>01/02/2021</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																								
✓		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.	PULSE /mins.	HEARING L R	VISION				Colour Vision	Blood Group													
172 cm		71 kg	24.0	130 80 mmHg	70 bdy		DISTANT		NEAR																
							R	L	R	L															
							Uncorrected	6/6	9/6	6/6															
							Corrected	6/6	9/6	6/6															
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																							

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

ASSESSMENT:

FIT ALL AREAS

FIT WITH RESTRICTION

TEMPORARY UNFIT UNFIT

Dat

Name (Block Capitals): Dr.

Signature:

REVIEW/CONSULTATION

Date:

Name (Block Capitals): Dr.

Signature:

DEPARTMENT OF LABORATORY MEDICINE

File No: 218743	Report No: 0563903		
Name: MUHAMMAD AMER SOHAIL	Sample Date: 02/02/2021	Time: 18:42	
Address:	Received By: SREEJAS		
Gender: M Age: 25 Y Nationality: PAKISTANI	Received Date: 02/02/2021	Time: 18:50	
GSM No.: 95359120 ID Card No.: 107709168	Report Date: 02/02/2021	Time: 19:10	
Ref. By: EXTERNAL DOCTOR	Bill No: 0744640	Bill Date: 01/02/2021	
	Report Status: Final		

INVESTIGATION	RESULT	REFERENCE RANGE
PDO MEDICAL CHECK UP BELOW 40 (Truckoman)		
FBS (FASTING BLOOD SUGAR)	5.47 mmol/L	3.9 - 6.1
Method :- Hexokinase	98.46 mg/dL	70 - 110
LIPID PROFILE - SERUM		
CHOLESTEROL (TOTAL)	5.41 mmol/L	1 - 5.1
Method:-Enzymatic	209.15 mg/dl	40 - 200
HDL (HIGH DENSITY LIPOPROTEIN)	1.04 mmol/L	0.777 - 1.813
" "	40.0 mg/dl	30 - 70
LDL (LOW DENSITY LIPOPROTEIN)	3.47 mmol/L	1.295 - 4.54
" "	134.1	50 - 172
VLDL (VERY LOW DENSITY LIPOPROTEIN)	0.91 mmol/L	0.259 - 1.036
" "	35.05 mg/dl	10 - 40
RATIO (TOTAL CHOL / HDL CHOL)	5.2	3.8 - 5.9
TRIGLYCERIDES	1.98 mmol/L	0.564 - 2.146
Method : Enzymatic	175.23 mg/dl	50 - 190
LIVER FUNCTION TEST - SERUM		
TOTAL BILIRUBIN - SERUM	0.45 mg/dL	0.1 - 1
Method : Diazo	7.70 µmol/L	1 - 17.1
DIRECT BILIRUBIN - SERUM	0.14 mg/dL	0.1 - 0.5
Method : Diazo	2.32 µmol/L	1 - 8.55
SGOT (AST)-SERUM (IFCC)	20.80 U/L	Male: up to 40.0 Female: up to 32.0
SGPT (ALT)-SERUM (IFCC)	36.70 U/L	Male: 10-50 Female: 10-35
ALKALINE PHOSPHATASE (ALP)-SERUM (IFCC)	80.99 U/L	Adult : Men -40-129

Processed By:
SREEJAS
Lab Technologist
MOH License No: 11155

Approved By:
SREEJAS
Lab Technologist

SREEJAS.
Lab Technologist
Released By:
MOH 11155
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Specialist Pathologist

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Page 1 of 4

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A Unit of DM Healthcare LLC

مستشفى عمان الخير

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هاتف: +٩٦٨ ٢٥٦٨٨٧٥ فاكس: +٩٦٨ ٢٥٦٨٨٠٥
البريد الإلكتروني: oakh.ibri@asterhospital.com
www.asterhospital.com
وحدة من مجموعة دموين للرعاية الصحية