

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

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|
| Surname: <b>ASGHAR MUHAMMED</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                |
| Forenames: <b>ADAN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                |
| Address: <b>Idri</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                |
| Home telephone number:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                |
| Place of examination:<br>Aster Hospital, Ibri                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Date: <b>11/2/21</b>                                                                                           |
| If a dependant enter employee's name here:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                |
| Project:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                |
| Birth date: <b>12/2/1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Nationality: <b>Pakistan</b>                                                                                   |
| Country of birth:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Religion:                                                                                                      |
| <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated / Divorced |
| Relationship to employee<br><input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                |
| Number of children:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                |
| Reason for examination<br>Pre-Employment <input type="checkbox"/> Job:<br>Pre-Overseas <input type="checkbox"/> Area:                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                |
| Name and address of family doctor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | List your last 3 jobs<br>(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.)                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                |
| Y N                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Y N                                                                                                            |
| 1. Sinus trouble                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 21. Cancer                                                                                                     |
| 2. Neck swelling/glands                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 22. Heart Disease                                                                                              |
| 3. Difficulty in vision                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 23. Rheumatic fever                                                                                            |
| 4. Any ear discharge                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 24. Abnormal heartbeat                                                                                         |
| 5. Asthma/bronchitis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 25. High blood pressure                                                                                        |
| 6. Hayfever /other significant allergy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 26. Stroke                                                                                                     |
| 7. Any skin trouble                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 27. Serious chest pain                                                                                         |
| 8. Tuberculosis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 28. Any blood disease                                                                                          |
| 9. Shortness of breath                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 29. Kidney disease                                                                                             |
| 10. Coughed/vomited blood                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 30. Blood in urine                                                                                             |
| 11. Severe abdominal pain                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 31. Diabetes                                                                                                   |
| 12. Stomach ulcer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 32. Headaches/migraine                                                                                         |
| 13. Recurrent indigestion                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 33. Dizziness/fainting                                                                                         |
| 14. Jaundice or hepatitis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 34. Epilepsy                                                                                                   |
| 15. Gall Bladder disease                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 35. Joints/spinal trouble                                                                                      |
| 16. Marked change in bowel habits                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 36. Surgical operation                                                                                         |
| 17. Blood in stools (motions)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 37. Serious accident/fracture                                                                                  |
| 18. Marked change in weight                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 38. Tropical disease                                                                                           |
| 19. Varicose veins                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 39. Fear of heights                                                                                            |
| 20. Lump in breast/armpit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                |
| <b>HAVE YOU EVER BEEN:-</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                |
| 40. Rejected for employment or insurance for medical reasons                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                |
| 41. Awarded benefits for industrial injury/illness                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                |
| 42. Treated for a mental condition, e.g. depression                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                |
| 43. Treated for problem drinking or drug abuse                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                |
| 44. Exposed to toxic substance or noise                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                |
| <b>FOR WOMEN ONLY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                |
| Have you ever had:-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                |
| 45. An abnormal smear                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                |
| 46. Any gynaecological treatment                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                |
| 47. Are you pregnant?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                |
| 48. Have you had an illness not mentioned above                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                |
| 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 ( )<br>Heart disease ( ) High blood pressure ( ) Stroke ( ) Blood Disease ( ) Cancer ( )                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                |
| <b>PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT:-</b><br>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: <b>11/2/21</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Signature of Applicant: <b>[Signature]</b>                                                                     |

**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<br>cm | WEIGHT<br>kg | BMI  | B.P.      | PULSE     | HEARING | VISION      |   |         |   | Colour<br>Vision | Blood Group |
|--------------|--------------|------|-----------|-----------|---------|-------------|---|---------|---|------------------|-------------|
| 174cm        | 75kg         | 24.8 | 140<br>90 | 94 /mins. | L<br>R  | DISTANT     |   | NEAR    |   |                  |             |
|              |              |      |           |           |         | R           | L | R       | L |                  |             |
|              |              |      |           |           |         | Uncorrected |   | 6/6 6/6 |   |                  |             |
|              |              |      |           |           |         | Corrected   |   |         |   |                  |             |

| N | A |                        | LABORATORY AND OTHER<br>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. Sickie Cell test    |                                                |   |   | 12. HIV, Hepatitis screening     |

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

## ASSESSMENT:

☒ FIT ALL AREAS ☐ FIT WITH RESTRICTION ☐ TEMPORARY UNFIT ☐ UNFIT

Date: 11/02/21 Name (Block Capitals): Dr. Kiran Raveendran Nair

## REVIEW/CONSULTATION

Date: Name (Block Capitals): Dr.

Signature:

د. كيران رافيندران ناير  
DR. KIRAN RAVEENDRAN NAIR  
رقم الترخيص: 8861  
LISCENCE NO: 8861  
طبيب عام  
GENERAL PRACTITIONER



DEPARTMENT OF LABORATORY MEDICINE

**File No:** 0219205  
**Name:** ADNAN ASGHAR MUHAMMED ASGHAR  
**Address:**  
**Gender:** M **Age:** 27 Y **Nationality:** PAKISTANI  
**GSM No.:** 93862827 **ID Card No.:** 106450284  
**Ref. By:** EXTERNAL DOCTOR

**Report No:** 0564738  
**Sample Date:** 11/02/2021 **Time:** 17:50  
**Received By:** ASHWINI  
**Received Date:** 11/02/2021 **Time:** 17:56  
**Report Date:** 11/02/2021 **Time:** 18:55  
**Bill No:** 0745843 **Bill Date:** 11/02/2021  
**Report Status:** Preliminary

| INVESTIGATION                             | RESULT       | REFERENCE RANGE                        |
|-------------------------------------------|--------------|----------------------------------------|
| PDO MEDICAL CHECK UP BELOW 40 (Truckoman) |              |                                        |
| FBS (FASTING BLOOD SUGAR)                 | 5.35 mmol/L  | 3.9 - 6.1                              |
| Method :- Hexokinase                      | 96.3 mg/dL   | 70 - 110                               |
| LIPID PROFILE - SERUM                     |              |                                        |
| CHOLESTEROL (TOTAL)                       | 6.18 mmol/L  | 1 - 5.1                                |
| Method:-Enzymatic                         | 238.92 mg/dl | 40 - 200                               |
| HDL (HIGH DENSITY LIPOPROTEIN)            | 1.04 mmol/L  | 0.777 - 1.813                          |
| " "                                       | 40 mg/dl     | 30 - 70                                |
| LDL (LOW DENSITY LIPOPROTEIN)             | 3.93 mmol/L  | 1.295 - 4.54                           |
| " "                                       | 151.84       | 50 - 172                               |
| VLDL (VERY LOW DENSITY LIPOPROTEIN)       | 1.22 mmol/L  | 0.259 - 1.036                          |
| " "                                       | 47.08 mg/dl  | 10 - 40                                |
| RATIO (TOTAL CHOL / HDL CHOL)             | 5.94         | 3.8 - 5.9                              |
| TRIGLYCERIDES                             | 2.66 mmol/L  | 0.564 - 2.146                          |
| Method : Enzymatic                        | 235.41 mg/dl | 50 - 190                               |
| LIVER FUNCTION TEST - SERUM               |              |                                        |
| TOTAL BILIRUBIN - SERUM                   | 0.39 mg/dL   | 0.1 - 1                                |
| Method : Diazo                            | 6.70 µmol/L  | 1 - 17.1                               |
| DIRECT BILIRUBIN - SERUM                  | 0.23 mg/dL   | 0.1 - 0.5                              |
| Method : Diazo                            | 3.99 µmol/L  | 1 - 8.55                               |
| SGOT (AST)-SERUM (IFCC)                   | 27.60 U/L    | Male: up to 40.0<br>Female: up to 32.0 |
| SGPT (ALT)-SERUM (IFCC)                   | 44.60 U/L    | Male: 10-50<br>Female: 10-35           |
| ALKALINE PHOSPHATASE (ALP)-SERUM (IFCC)   | 102.35 U/L   | Adult : Men -40-129                    |

Processed By:  
JIBI

Approved By:

Released By:  
ASHWINI

Lab Technologist

Lab Technologist

Lab Technologist

Specialist Pathologist

MOH LIC No: 4384

MOH License No: 16064

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Page 1 of 4

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وحدة من مجموعة د.موبين للرعاية الصحية