BADR
مستشفى بدر السماء
BADR AL SAMAA HOSPITAL
AL KHOUD, SULTANATE OF OMAN الخوض، سلطنة عمان
More Than Healthcare ...Humane Care

MEDICAL FITNESS CERTIFICATE

OQ MEDICAL

NAME	GURUMURTHY VALISETTI

NATIONALITY	INDIAN

CIVIL NUMBER	70701263	
DATE OF BIRTH	09/04/1984	
VISION	R-6/6	L- 6/6
COLOR VISION	PRESENT	
BLOOD PRESSURE	120/80	

Date	24/02/2024
SEX	MALE
HEIGHT	170 CM
WEIGHT	83 KG
PULSE	72 MIN

INVESTIGATIONS

FBS,CBC	NORMAL
LFT,RFT	NORMAL
URINE ROUTINE & MIC	NORMAL
LIPID PROFILE	NORMAL
BLOOD GROUP	A POSITIVE
STOOL TEST	NEGATIVE
AUDIOGRAM	RIGHT-HEARING SENSITIVITY WITHIN NORMAL LIMITS. LEFT-HEARING SENSITIVITY WITHIN NORMAL LIMITS EXCEPT AT HIGH FREQUENCIES.
CHEST XRAY REPORT	NORMAL
LUMBAR X RAY REPORT	MILD STRAIGHTENING OF LS SPINE WITH LOSS OF NORMAL LORDOSIS
ECG	NORMAL

CONCLUSION: ***MEDICALLY FIT FOR JOB***

FIT

Signature: Cardiology opinion

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المقر الرئيسي :
س.ت : ١٦٩١٨٠٨، ص.ب: ٤٤٣، الرمز البريدي: ١١٢
بوي، سلطنة عمان، هاتف: ٢٤٧٩٩٧٦٠، فاكس: ٢٤٧٩٩٧٠٥
الخوير: ٢٤٤٨٨٣٢٢ | صحار: ٢٦٨٤٦٦٦٠ | الخوض: ٢٤٥٤٦٠٩٩ | صلالة: ٢٣٢٩١٨٣٠
بركاء: ٢٦٨٨٤٩١٠ | صور: ٢٥٥٤٦١١٢ | نزوى: ٢٥٤٤٧٧٧٧ | فلج: ٢٦٧٥٤١٣١
البريد الإلكتروني: info@badroman.com

Instructions for Medical Examination
Contractors

Refer to the OHI-0001 Occupational Medical Examination for the tests/investigations/assessments required as per position, contract period, critical activities.

The tests/investigations/assessments shall be conducted in hospital and/or polyclinic specialized in medical checkups.

MEDICAL EVALUATION REPORT - SUMMARY
Shall be filled out by clinic doctor and summarize all tests, investigations and assessment performed

FITNESS TO WORK CERTIFICATE
Shall be filled out by clinic doctor responsible for the assessment and conclusion of the fitness

MEDICAL & SURGICAL HISTORY QUESTIONNAIRE
Shall be filled out by the employee and reviewed by clinic doctor during the physical assessment

SCREENING QUESTIONNAIRE
Shall be filled out by the employee and reviewed by clinic doctor during the physical assessment

RESPIRATORY PROTECTION QUESTIONNAIRE
Shall be filled out by the workers will be exposed to chemical hazards and reviewed by the clinic doctor during the physical assessment

HEARING CONSERVATION QUESTIONNAIRE

Shall be filled out by the workers will be exposed to noise and reviewed by the clinic doctor during the physical assessment

PHYSICAL ASSESSMENT FORM
Shall be filled out during the performance of tests/investigations and physical assessment

The reports indicated below shall be uploaded in the online shared folder indicated by OQ:
_ Medical Evaluation Report - Summary
_ Fitness to Work Certificate
_ Lab Reports
_ ECG Report (if indicated)
_ X-ray Report (if indicated)
_ Audiometry Report (if indicated)
_ Spirometry Report (if indicated)

<u>The electronic file shall comply with the requirements:</u>
File name -- Company Name - Employee ID# - Employee Name
File size -- maximum 1GB
File type -- pdf
File limit -- 1 file per employee with all reports indicated above

MEDICAL EVALUATION REPORT FOR OQ CONTRACTORS - SUMMARY

OQ

CANDIDATE / EMPLOYEE IDENTIFICATION

Civil ID / Passport #	Company ID #	Name	Position
30701263		GURUMURTHY VALISETTI	

Nationality	Age	Sex	Company	Location
INDIAN	39	M		

EXAMINATION TYPE

Examination [ ] Pre-employment [ ] Periodic [ ] Exit

VITAL SIGNS & BODY MEASURES

Blood Pressure Category: ____ [✓] Normal [ ] Prehypertension [ ] Hypertension Stage 1 [ ] Hypertension Stage 2 [ ] Hypertension Crises

BMI Category: ____ [ ] Underweight [ ] Normal [ ] Overweight [ ] Obese [ ] Morbid Obesity

Remarks:

VISUAL TEST

Visual Acuity Test: RT 6/6 - LT 6/6 Visual Field Test [✓] Normal [ ] Abnormal

Colour Vision Test [ ] Normal [ ] Abnormal [ ] Not Required Stereoscopic Vision Test [✓] Normal [ ] Abnormal [ ] Not Required

Pre-existing condition:

Remarks:

RESPIRATORY SYSTEM

Spirometry Test [✓] Normal [ ] Abnormal [ ] Not Required Chest X-Ray [✓] Normal [ ] Abnormal [ ] Not Required

Pre-existing condition: Physical Assessment [✓] Normal [ ] Abnormal

Remarks:

ENT SYSTEM

Audiometry Test [✓] Normal [ ] Abnormal [ ] Not Required Otoscopy [✓] Normal [ ] Abnormal [ ] Not Required

Pre-existing condition: Physical Assessment [✓] Normal [ ] Abnormal (Whisper, Weber & Rinne Tests)

Remarks:

CARDIOVASCULAR SYSTEM

ECG Test [✓] Normal [ ] Abnormal [ ] Not Required Physical Assessment [✓] Normal [ ] Abnormal

Pre-existing condition:

Remarks:

NEUROLOGICAL SYSTEM

Physical Assessment [✓] Normal [ ] Abnormal

Pre-existing condition:

Remarks:

MUSCULOSKELETAL SYSTEM

Physical Assess. [✓] Normal [ ] Abnormal Lumbar X-Ray [✓] Normal [ ] Abnormal [ ] Not Required

Pre-existing condition:

Remarks:

LABORATORY INVESTIGATIONS

Lab Tests: [✓] Normal [ ] Abnormal If abnormal, please specify below: Blood Grouping:

Pre-existing condition:

Remarks:

Glucose Level Category ____ [✓] Normal 80 – 100 mg/dl [ ] Pre diabetic 100 – 125 mg/dl [ ] Diabetic > 126 mg/dl

Cholesterol Risk Category ____ [ ] Low Risk LDL is less 130 mg/dl [ ] Moderate Risk LDL 130-159 mg/dl [ ] High Risk LDL >160 mg/dl

Routine Urine Analysis [ ] Normal [ ] Abnormal [ ] Not Required Stool Analysis [ ] Normal [ ] Abnormal [ ] Not Required

QUESTIONNAIRES

	Medical & Surgical History Questionnaire	Remarks
	Respiratory Protection Questionnaire	Remarks
	Hearing Conservation Questionnaire	Remarks
	Screening Questionnaire	Remarks

Fagerstrom Test - Smoking [ ] Non-smoker [ ] Low dependence [ ] Low to Mod dependence [ ] Moderate dependence [ ] High dependance

CAGE Questionnaire Alcohol Use [ ] No use of alcohol [ ] Screening negative [ ] Clinically significant

SRQ-20 Self-reported Questionnaire [ ] No positive answers [ ] Positive answers Factor I (1 to 6) [ ] Positive answers Factor II (7 to 12)

[ ] Positive answers Factor III (13 to 16) [ ] Positive answers Factor IV (17 to 20)

Clinic Doctor Name	License #	Hospital/Policlinic	Doctor Signature & Clinic Stamp	Issue Date
DR. JENJUN JOSE		BADR AL KHOUD		29/2/2024

FITNESS TO WORK CERTIFICATE - OQ CONTRACTORS

OQ

EMPLOYEE IDENTIFICATION

Civil ID / Passport #	Company ID #	Name	Position
70701263		GURUMURTHY VALISETTI	

Nationality	Age	Sex	Company	Location
INDIAN	39	M.		

EXAMINATION TYPE

[ ] Pre-employment Examination (PRE)	[ ] Periodic Medical Examination (PME)	[ ] Post-absence Examination
[ ] Change of Position Examination	[ ] Exit Examination	[ ] Critical Activities Examination
[ ] Emergency Response Team	[ ] Travelling Examinations	[ ] Medical Surveillance

Medical Suitability for Work

Medical Suitability for Work	[✓] Fit to work [ ] Fit with following restrictions [ ] Pending Fitness [ ] Not fit to work

Restrictions

[ ] Working at height	[ ] Pulling, pushing or carrying weight
[ ] Working in confined space	[ ] Ascend/descend ladders and stairs
[ ] Working with electricity	[ ] Walking or standing for long distance/period
[ ] Working near rotating machinery	[ ] Repetitive movements
[ ] Working in noise area	[ ] Mobile machinery operation
[ ] Working in extreme heat	[ ] Heavy lifting operation
[ ] Handling chemical products	[ ] Driving vehicle
[ ] Use of respirator	[ ] Emergency response duty

Other, specify

New Position	New Function	New Department
NA	NA	NA

Examanation Date	Exams Performed

Medical Review Date	Employee Signature

Doctor Name	Medical License	Hospital	Medical Doctor Signature
DR. RENJITH JOSE			

Dr. Renjith Jose
MBBS, MD,
PG Dip Diabetes
Specialist Internal Medicine
[illegible] 67715

MEDICAL & SURGICAL HISTORY QUESTIONNAIRE

CANDIDATE / EMPLOYEE IDENTIFICATION

Civil ID / Passport #	Company ID #	Name	Position
70701263		GURUMURTHY VALISETTI	

Nationality	Age	Sex	Company	Location
INDIAN	39	M		

PERSONAL HEALTH HISTORY

Have you ever, or do you currently suffer from any of the following?

Congenital heart disease or Valvular heart disease or Coronary artery disease		Yes	✓	No	Muscle problems e.g. weakness of your limbs or twitchy muscles		Yes	✓	No
Myocardial insufficiency or infarction (heart attack)		Yes	✓	No	Joint problems, e.g. plantar warts, joint pain or swelling		Yes	✓	No
Coronary bypass surgery (CABS) and angioplasty		Yes	✓	No	Problems with limb, neck or spine mobility		Yes	✓	No
Heart arrhythmias (heart beats too fast, too slow or irregularly)		Yes	✓	No	Extremities (feet or hands) deformities or problems		Yes	✓	No
High blood pressure (hypertension)		Yes	✓	No	Experienced back problem, arthritis, slipped disc		Yes	✓	No
Shortness of breath after exertion		Yes	✓	No	Pain in neck or back or hands or legs		Yes	✓	No
Varicose veins associated with varicose eczema, ulcers or other complications		Yes	✓	No	Thyroid disease any other glandular diseases		Yes	✓	No
Arteriosclerotic or other vascular disease		Yes	✓	No	Diabetes mellitus or Hypoglycaemia		Yes	✓	No
Anaemias, especially Sickle Cell Disease or Sickle Cell Trait or Thalassemia		Yes	✓	No	Experienced weight loss or gain > 5kg over the past year		Yes	✓	No
Haemorrage disorders i.e. bleeding disorders		Yes	✓	No	Informed about being overweight or obese		Yes	✓	No
Leukaemia, polycythaemia and disorders of the reticulo-endothelial system		Yes	✓	No	Skin disorders e.g. severe acne, dermatitis, eczema or allergy		Yes	✓	No
G6PD (Glucose 6-Phosphate Dehydrogenase) Deficiency		Yes	✓	No	Allergies e.g. dust, medication, insect bites		Yes	✓	No
Recurrent headaches or migraine		Yes	✓	No	Disorders of the digestive tract e.g. ulcers, recurrent diarrhea, gastritis		Yes	✓	No
Epilepsy and recurrent seizures		Yes	✓	No	Haemorrhoids, fistulae and fissures causing pain, or recurrent bleeding		Yes	✓	No
Blackouts, dizziness, fainting, memory loss, unconsciousness (vertigo/syncope)		Yes	✓	No	Liver and pancreas diseases (e.g. pancreatitis, Hepatitis B)		Yes	✓	No
Sleep disorders, such as insomnia, hypersomnia, sleep apnea, narcolepsy		Yes	✓	No	Kidney or bladder diseases e.g. recurrent infection, renal stones		Yes	✓	No
Chronic anxiety states and/or recurrent depression		Yes	✓	No	Ear, nose or throat problems (e.g. otitis, hearing loss, sinusitis, tonsillitis)		Yes	✓	No
Phobias such as fear of heights, fear of confined spaces, fear of flying		Yes	✓	No	Eye disease or visual defect (e.g. glaucoma, color blindness, monocular vision)		Yes	✓	No
Lung disease e.g. bronchitis, asthma, dyspnea, TB		Yes	✓	No	Treated for infectious diseases (e.g. malaria, COVID19)		Yes	✓	No
Phlegm production (excess mucus production) or tight chest		Yes	✓	No	Treated for depression, stress		Yes	✓	No
Immuno suppression due to cancer or human immunodeficiency virus		Yes	✓	No	Treated for substance or alcohol abuse		Yes	✓	No

Have you visited a doctor in the last year?		Yes	✓ No
Are you taking any medication at present?		Yes	✓ No
Are you pregnant?		Yes	✓ No

List any previous injuries or operations

Previous injuries or operations	Date

Date: 29/02/2024

Candidate/Employee Signature
V. Guruji

SCREENING QUESTIONNAIRE

OQ

CANDIDATE / EMPLOYEE IDENTIFICATION

Civil ID / Passport #	Company ID #	Name	Position
70701263		GURUMURTHY VALUSETTI	

Nationality	Age	Sex	Company	Location
INDIAN	39	M.		

FAGERSTROM TEST

Do you smoke? [ ] Yes [✓] No *If YES, Please answer the following:*

How soon after waking up do you smoke you first cigarette?	[ ] >60min	[ ] 31-60min	[ ] 6-30min	[ ] < 5 minutes	[ ]
Do you find it difficult to avoid smoking where is forbidden, such as work places, cinemas, shopping etc.?			[ ] Yes	[ ] No	[ ]
What's the most difficult cigarette to quit or not to smoke	[ ] Anyone	[ ] The first in the morning			[ ]
How many cigarettes do you smoke per day	[ ] <10	[ ] 11-20	[ ] 21-30	[ ] >31	[ ]
Do you smoke more frequently the first hours of the day than the rest of the day		[ ] Yes	[ ] No		[ ]
Do you smoke even when you're sick and have to stay in the bed most part of the day		[ ] Yes	[ ] No		[ ]

CAGE QUESTIONNAIRE

Do you drink alcohol? [ ] Yes [✓] No *If YES, Please answer the following:*

Did you ever felt that you should decrease the amount of drinks or cut down (stop) drinking?	[ ] Yes	[ ] No	[ ]
Do people bother you because they criticize the way you drink?	[ ] Yes	[ ] No	[ ]
Do you feel guilty or upset with yourself with the way you use to drink	[ ] Yes	[ ] No	[ ]
Do you drink in the morning to feel less nervous or decrease the hang over	[ ] Yes	[ ] No	[ ]
Have you had any problems related to alcohol	[ ] Yes	[ ] No	
Did you drink in the last 24 hours	[ ] Yes	[ ] No	

FATIGUE QUESTIONNAIRE

Have you noticed that you are feeling tired recently [ ] Yes [✓] No

Have you been feeling a lack of energy [ ] Yes [✓] No *If YES, Please answer the following:*

For how many days did you feel tired or with lack of energy in the last week	[ ] 1 day	[ ] 2 days	[ ] 3 days	[ ] > 3 days
Did you feel tired or with lack of energy for more than 3 hs in some days last week?	[ ] 1 hour	[ ] 2 hours	[ ] 3 hours	[ ] > 3 hours
Did you feel so tired that you had to make some effort to do things last week	[ ] Yes	[ ] No		
Did you feel tired or with lack of energy doing things you like last week	[ ] Yes	[ ] No		

SELF-REPORTING QUESTIONNAIRE (SRQ-20)

1.Do you have trouble thinking clearly?	[ ] Yes	[✓] No	11.Is your digestion not good?	[ ] Yes	[✓] No
2.Do you find it hard to like your daily work?	[ ] Yes	[✓] No	12.Do you have unpleasant sensations in your stomach	[ ] Yes	[✓] No
3.Do you find difficult taking decisions?	[ ] Yes	[✓] No	13.Do you get scared easily?	[ ] Yes	[✓] No
4.Is your daily work a suffering?	[ ] Yes	[✓] No	14.Do you feel nervous, tense or worried?	[ ] Yes	[✓] No
5.Do you feel tired all the time?	[ ] Yes	[✓] No	15.Do you feel unhappy?	[ ] Yes	[✓] No
6.Are you easily tired?	[ ] Yes	[✓] No	16.Do you cry more than usual?	[ ] Yes	[✓] No
7.Do you have frequent headaches?	[ ] Yes	[✓] No	17.Has the thought of ending your life been on your mind?	[ ] Yes	[✓] No
8.Do you feel lack of hunger?	[ ] Yes	[✓] No	18.Do you find it difficult to perform your work?	[ ] Yes	[✓] No
9.Do you sleep badly?	[ ] Yes	[✓] No	19.Have you lost interest in things?	[ ] Yes	[✓] No
10.Do your hands tremble?	[ ] Yes	[✓] No	20.Do you feel you're worthless?	[ ] Yes	[✓] No

Date: 24/02/2024

Candidate/Employee Signature
V. Gurumurthy

RESPIRATORY PROTECTION QUESTIONNAIRE

CANDIDATE / EMPLOYEE IDENTIFICATION

Civil ID / Passport #	Company ID #	Name	Position
70701263		GURUMURTHY VADLAKOTTI	

Nationality	Age	Sex	Company	Location
INDIAN	39	M.		

RESPIRATORY PROTECTION MEDICAL EVALUATION QUESTIONNAIRE - OSHA

Do you use a respirator? [ ] YES [ ] NO What type: ☐ Disposible mask ☐ Cartidge Mask ☐ SCBA

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? [ ] YES [ ] NO

2. Have you ever had any of the following conditions?

[ ] YES [ ] NO a. Seizures [ ] YES [ ] NO c. Trouble smelling odors [ ] YES [ ] NO e. Claustrophobia (fear of closed in places)
[ ] YES [ ] NO b. Diabetes (sugar disease) [ ] YES [ ] NO d. Allergic reactions that interfere with your breathing

3. Have you ever had any of the following pulmonary or lung problems?

[ ] YES [ ] NO a. Asbestosis [ ] YES [ ] NO e. Pneumonia [ ] YES [ ] NO i. Broken ribs
[ ] YES [ ] NO b. Asthma [ ] YES [ ] NO f. Tuberculosis [ ] YES [ ] NO j. Pneumothorax (collapsed lung)
[ ] YES [ ] NO c. Chronic bronchitis [ ] YES [ ] NO g. Silicosis [ ] YES [ ] NO k. Any chest injuries or surgeries
[ ] YES [ ] NO d. Emphysema [ ] YES [ ] NO h. Lung cancer [ ] YES [ ] NO l. Any other lung problem that you have been told about

4. Do you currently have any of the following symptoms of pulmonary or lung illness?

[ ] YES [ ] NO a. Shortness of breath [ ] YES [ ] NO h. Coughing that wakes you early in the morning
[ ] YES [ ] NO b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline [ ] YES [ ] NO i. Coughing that occurs mostly when you are lying down
[ ] YES [ ] NO c. Shortness of breath when walking with other people at an ordinary pace on level ground [ ] YES [ ] NO j. Coughing up blood in the last month
[ ] YES [ ] NO d. Have to stop for breath when walking at your own pace on level ground [ ] YES [ ] NO k. Wheezing
[ ] YES [ ] NO e. Shortness of breath when washing or dressing yourself [ ] YES [ ] NO l. Wheezing that interferes with your job
[ ] YES [ ] NO f. Shortness of breath that interferes with your job [ ] YES [ ] NO m. Chest pain when you breathe deeply
[ ] YES [ ] NO g. Coughing that produces phlegm (thick sputum) [ ] YES [ ] NO n. Any other symptoms that you think may be related to lung problems

5. Have you ever had any of the following cardiovascular or heart problems?

[ ] YES [ ] NO a. Heart attack [ ] YES [ ] NO e. Swelling in your legs or feet (not caused by walking)
[ ] YES [ ] NO b. Stroke [ ] YES [ ] NO f. Heart arrhythmia
[ ] YES [ ] NO c. Angina [ ] YES [ ] NO g. High blood pressure
[ ] YES [ ] NO d. Heart failure [ ] YES [ ] NO h. Any other heart problems that you've been told about

6. Have you ever had any of the following cardiovascular or heart symptoms?

[ ] YES [ ] NO a. Frequent pain or tightness in your chest [ ] YES [ ] NO e. Heartburn or indigestion that is not related to eating
[ ] YES [ ] NO b. Pain or tightness in your chest during physical activity [ ] YES [ ] NO f. Any other symptoms that you think might be related to heart
[ ] YES [ ] NO c. Pain or tightness in your chest that interferes with your job
[ ] YES [ ] NO d. In the past two years, have you noticed your heart skipping or missing a beat

7. Do you currently take medication for any of the following problems?

[ ] YES [ ] NO a. Breathing or lung problems [ ] YES [ ] NO c. Blood pressure
[ ] YES [ ] NO b. Heart trouble [ ] YES [ ] NO d. Seizures (fits)

8. If you've used a respirator, have you ever had any of the following problems?

[ ] YES [ ] NO a. Eye irritation [ ] YES [ ] NO d. General weakness or fatigue
[ ] YES [ ] NO b. Skin allergies or rashes [ ] YES [ ] NO e. Any other problem that interfere with your use of a respirator
[ ] YES [ ] NO c. Anxiety

Date: 24/02/2024

Candidate/Employee Signature

HEARING CONSERVATION QUESTIONNAIRE

OQ

CANDIDATE / EMPLOYEE IDENTIFICATION

Civil ID / Passport #	Company ID #	Name	Position
70701263		GURUMURTHY VALUSETTI	

Nationality	Age	Sex	Company	Location
INDIAN	39	M		

HEARING CONSERVATION MEDICAL EVALUATION QUESTIONNAIRE - OSHA

Do you use hearing protection? [ ] YES [✓] NO What type: ☐ Earplugs ☐ Ear Muffs ☐ Double HP

1 - Have you been out of noise for the past 14-16 hours? [ ] YES [ ] NO
If NO, did you use hearing protection while in the noise? [ ] YES [ ] NO

2 - Check ALL of the following activities that you have done or do:

[ ] Hunting [ ] Car races [ ] Skeet shooting [ ] Woodwork [ ] Target shooting
[ ] Power tools [ ] Mower [ ] Concerts / Band [ ] Welding [ ] Air compressor
[ ] Construction [ ] Scuba diving [ ] Tractor (open or closed cab)

Have you ALWAYS used hearing protection when participating in the above activities? [ ] YES [ ] NO

3 - Check ALL that you have experienced:

[ ] Ear Fullness [ ] Ear Infections [ ] Ear Surgery [ ] Head Injury [ ] Chemotherapy
[ ] Ringing in the ears [ ] Ear Pain [ ] Earwax buildup [ ] Intravenous Antibiotics [ ] Hole in the Eardrum
[ ] Ear Drainage [ ] Dizziness

4 - Check ALL that you have had/suffered from:

[ ] Meningitis [ ] Diabetes [ ] Measles [ ] Syphilis [ ] Chickenpox [ ] Mumps [ ] Chronic ear infections
[ ] Hypertension [ ] Renal Failure [ ] Tuberculosis [ ] Previous surgery [ ] Thyroid Problems [ ] Trauma to head/ ear canal / tympanic membrane

5 - Check ALL that you are currently suffering from:

[ ] Sinusitis [ ] Cold/Flu [ ] Ear Infection [ ] Allergic rhinitis

6 - Do you have documented Hearing Loss? [ ] YES [ ] NO
If Yes: Which Ear(s)? [ ] Right Ear [ ] Left Ear [ ] Both Ear Who performed your hearing test?

7 - Have you EVER worn Hearing Aids? [ ] YES [ ] NO
If Yes: Which Ear(s) [ ] Right Ear [ ] Left Ear [ ] Both Ear
What Size? [ ] Behind-the-ear [ ] In-the-ear [ ] In-the-canal [ ] Completely-in-the-canal
What Type? [ ] Analog [ ] Digital
Who fit your hearing aids? [ ] Licensed Audiologist [ ] Hearing Aid Dealer [ ] Don't Know
When did you receive your hearing aids?

8 - Have you ever served in the military? [ ] YES [ ] NO
If yes, check division [ ] Arm [ ] Navy [ ] Air Force [ ] Marines [ ] National Guard Date ___/___/___
Do you have medical disability through the Veterans Administration (VA) for hearing loss or tinnitus? [ ] YES [ ] NO
If yes, how much? _____% What is your TOTAL VA disability? _____%

9 - Are you currently using any medication [ ] YES [ ] NO Which one?

10 - What kind of transport do you regularly use? [ ] Car [ ] Bus [ ] Motocycle [ ] Walking

Date: 24/02/2024

Candidate/Employee Signature
V. Gurumurthy

PHYSICAL ASSESSMENT FORM

CANDIDATE / EMPLOYEE IDENTIFICATION

Civil ID / Passport #	Company ID #	Name	Position
7070/263		GURUMURTHY VALUKATTI	

Nationality	Age	Sex	Company	Location
INDIAN	39	M.		

VITAL SIGNS

Height: 170 cm Weight: 83 Kg BMI: Blood Pressure: 120/80 mmHg

Pulse: 1000/50 /min 72 Medical Practitioner Name: Signature:

VISUAL SYSTEM

	Right Uncorrected	Left Uncorrected	Right Corrected	Left Corrected	Both Uncorrected	Both Corrected
Visual Acuity Test:	6/18	6/18	6/6	6/6		6/6

Colour Vision Test Ishihara: # of Plates passed | Inform the Plates # failed | ☑ Normal ☐ Abnormal

Visual Field Test: ☐ Normal ☐ Abnormal (completed not done)

Stereoscopic Vision Test: ☐ Normal ☐ Abnormal

Date of Examination: 22/8/2024 Medical Practitioner Name: Dr Shilpa Algudkar Signature:

Dr. SHILPA A
MBBS, DOMS,
OPHTHALMOLOGIST
MOH LICENCES NO. 8975

RESPIRATORY SYSTEM

[1] Spirometry Test

Smoking Status: ☐ Never ☐ Ever Used ☐ Current Patient's Posture During Test: ☐ Standing ☐ Sitting Nose Clips Used: ☐ Yes ☐ No

Diagnosis: ☐ Asthma ☐ COPD ☐ Other

Acceptability Criteria (select all what is applicable)	Repeatability Criteria (select all what is applicable)
☐ Free from artifacts ☐ Satisfactory exhalation ☐ Good start ☐ NOT satisfactory	☐ >3 acceptable curves FEV1 values AND FVC values within 0.15L (150 ml) ☐ Total of THREE to EIGHT tests performed ☐ The patient CAN NOT or SHOULD NOT continue

The Patient Demonstrated: ☐ Good Effort ☐ Difficulty following instructions ☐ Ability to obtain only one good effort ☐ Poor Effort ☐ Cooperation

Date of Examination: Medical Practitioner Name: Signature:

[2] Chest Shape and Movement		[3] Chest Percussion	
☐ Normal ☐ Abnormal ☐ Not Examined	If abnormal, describe below:	☐ Normal ☐ Abnormal ☐ Not Examined	If abnormal, describe below:
[3] Air Entry in Both Lungs		**[4] Breath sounds**	
☐ Normal ☐ Abnormal ☐ Not Examined	If abnormal, describe below:	☐ Normal ☐ Abnormal ☐ Not Examined	If abnormal, describe below:

Date of Examination: Physician Name: Signature:

ENT SYSTEM

[1] Otoscopy

	Right	Left		Right	[2] Hearing Test	
Ear Canal Collapse	☐ Yes ☑ No ☐ Not Exam	☐ Yes ☐ No ☐ Not Exam	Eardrum Position	☑ Normal ☐ Retracted ☐ Bulging ☐ Not Exam	Whisper Test	☑ Normal ☐ Abnormal ☐ Not Exam
Drainage	☐ Yes ☑ No ☐ Not Exam	☐ Yes ☑ No ☐ Unknown		Left: ☑ Normal ☐ Retracted ☐ Bulging ☐ Not Exam	Rinne Test	☑ Normal ☐ Abnormal ☐ Not Exam
Perforation	☐ Yes ☑ No ☐ Not Exam	☐ Yes ☐ No ☐ Not Exam	Eardrum Vascularity	Right: ☑ Normal ☐ Considerable ☐ Mild ☐ Not Exam	Weber Test	☐ Normal ☐ Abnormal ☐ Not Exam
Cerumen	Right: ☑ None ☐ Some	☐ A lot ☐ Impacted	☐ Not Exam	Left: ☑ Normal ☐ Considerable ☐ Mild ☐ Not Exam	Adiometry Done	☑ Yes ☐ No
	Left: ☑ None ☐ Some	☐ A lot ☐ Impacted	☐ Not Exam	Audiologist Name: Signature:	Hearing Questionnaire vetted	☐ Yes ☐ No

Dr. SABAH MOOSANKUTTY
MBBS, MS, DNB
ENT Surgeon
MOH License # 17968

JENCY JAMES
Audiologist
MOH License No. 24714

PHYSICAL ASSESSMENT FORM

ENT SYSTEM

[2] Nose Assessment	If abnormal, describe below:	[3] Throat Assessment	If abnormal, describe below:
☑ Normal ☐ Abnormal ☐ Not Examined		☑ Normal ☐ Abnormal ☐ Not Examined	

CARDIOVASCULAR SYSTEM

[1] Heart Sounds	If abnormal, describe below:	[2] Heart Murmurs	If present, describe below:
☑ Normal ☐ Abnormal ☐ Not Examined		☑ Present ☐ Absent ☐ Not Examined	
[3] Peripheral Pulses	**If abnormal, describe below:**	**[4] Peripheral Veins**	**If abnormal, describe below:**
☑ Normal ☐ Abnormal ☐ Not Examined		☑ Normal ☐ Abnormal ☐ Not Examined	

NEUROLOGICAL SYSTEM

[1] Mental Status	If abnormal, describe below:	[2] Cranial Nerves	If abnormal, describe below:
☑ Normal ☐ Abnormal ☐ Not Examined		☑ Normal ☐ Abnormal ☐ Not Examined	
[3] Motor System	**If abnormal, describe below:**	**[4] Reflexes**	**If abnormal, describe below:**
☑ Normal ☐ Abnormal ☐ Not Examined		☑ Normal ☐ Abnormal ☐ Not Examined	
[5] Sensory System	**If abnormal, describe below:**	**[6] Coordination, Station, Gait**	**If abnormal, describe below:**
☑ Normal ☐ Abnormal ☐ Not Examined		☑ Normal ☐ Abnormal ☐ Not Examined	

MUSCULOSKELETAL SYSTEM

[1] Hand and Wrist	If abnormal, describe below:	[2] Elbow and Shoulder	If abnormal, describe below:
☑ Normal ☐ Abnormal ☐ Not Examined		☑ Normal ☐ Abnormal ☐ Not Examined	
[3] Hip	**If abnormal, describe below:**	**[4] Knees**	**If abnormal, describe below:**
☑ Normal ☐ Abnormal ☐ Not Examined		☑ Normal ☐ Abnormal ☐ Not Examined	
[5] Foot and Ankle	**If abnormal, describe below:**	**[6] Spine and Back**	**If abnormal, describe below:**
☑ Normal ☐ Abnormal ☐ Not Examined		☑ Normal ☐ Abnormal ☐ Not Examined	

OTHER

[1] Skin, Extremities	If abnormal, describe below:	[2] Head & Neck	If abnormal, describe below:
☑ Normal ☐ Abnormal ☐ Not Examined		☑ Normal ☐ Abnormal ☐ Not Examined	
[3] Mouth and Teeth	**If abnormal, describe below:**	**[4] Hernial Orifices**	**If abnormal, describe below:**
☑ Normal ☐ Abnormal ☐ Not Examined		☑ Normal ☐ Abnormal ☐ Not Examined	
[5] Abdominal Organs	**If abnormal, describe below:**	**[6] Lymph Nodes**	**If abnormal, describe below:**
☑ Normal ☐ Abnormal ☐ Not Examined		☐ Normal ☐ Abnormal ☐ Not Examined	

Date of Examination: 29/02/2024 Physician Name: Dr. FENILIN JOSE Signature: _____

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