

# MEDICAL EVALUATION REPORT - SUMMARY



CANDIDATE / EMPLOYEE IDENTIFICATION				
Civil ID / Passport #	Company ID #	Name		Section
74981986		Jaswinder Singh		
Nationality	Age	Sex	Company	Location
Indian	41	M	Tack Omni	

**EXAMINATION TYPE**

Examination:  Pre-employment  Periodic  Exit

**VITAL SIGNS & BODY MEASURES**

Blood Pressure Category:  Normal  Prehypertension  Hypertension Stage 1  Hypertension Stage 2  Hypertension Crisis

BMI Category:  Underweight  Normal  Overweight  Obese  Morbid Obesity

Remarks:

**VISUAL TEST**

Visual Acuity Test: RT  Normal  Abnormal  Not Required; LT  Normal  Abnormal  Not Required

Colour Vision Test:  Normal  Abnormal  Not Required

Binocular Vision Test:  Normal  Abnormal  Not Required

Pre-existing condition: *nil*

Remarks:

**RESPIRATORY SYSTEM**

Spirometry Test:  Normal  Abnormal  Not Required

Chest X-Ray:  Normal  Abnormal  Not Required

Physical Assessment:  Normal  Abnormal

Pre-existing condition: *nil*

Remarks:

**ENT SYSTEM**

Auditory Test:  Normal  Abnormal  Not Required

Otology:  Normal  Abnormal  Not Required

Physical Assessment:  Normal  Abnormal (Weber, Weber & Rinne Tests)

Pre-existing condition: *nil*

Remarks:

**CARDIOVASCULAR SYSTEM**

ECG Test:  Normal  Abnormal  Not Required

Physical Assessment:  Normal  Abnormal

Pre-existing condition: *nil*

Remarks: *(Sinus Bradycardia)*

**NEUROLOGICAL SYSTEM**

Physical Assessment:  Normal  Abnormal

Pre-existing condition: *nil*

Remarks:

**MUSCULOSKELETAL SYSTEM**

Physical Assess:  Normal  Abnormal

Lumbar X-Ray:  Normal  Abnormal  Not Required

Pre-existing condition: *nil*

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 > 125 mg/dl

Cholesterol Risk Category:  Low Risk LDL < 130 mg/dl  Moderate Risk LDL 135-159 mg/dl  High Risk LDL > 160 mg/dl

Routine Urine Analysis:  Normal  Abnormal  Not Required

Stool Analysis:  Normal  Abnormal  Not Required

**QUESTIONNAIRES**

<input checked="" type="checkbox"/>	Medical & Surgical History Questionnaire	Remarks
<input checked="" type="checkbox"/>	Respiratory Protection Questionnaire	Remarks
<input checked="" type="checkbox"/>	Hearing Conservation Questionnaire	Remarks
<input checked="" type="checkbox"/>	Screening Questionnaire	Remarks

Pagestrom Test - Smoking:  Non-smoker  Low dependence  Low to Mod dependence  Moderate dependence  High dependence

CAQE Questionnaire Alcohol Use:  No use of alcohol  Screening negative  Clinically significant

ERG-20 Self-reported Questionnaire:  No positive answers  Positive answers Factor I (7 to 8)  Positive answers Factor II (7 to 12)  Positive answers Factor III (13 to 16)  Positive answers Factor IV (17 to 22)

Clinic Doctor Name: \_\_\_\_\_ License #: \_\_\_\_\_ Hospital/Clinic: \_\_\_\_\_ Doctor Signature & Clinic Stamp: \_\_\_\_\_ Issue Date: \_\_\_\_\_



# FITNESS TO WORK CERTIFICATE



EMPLOYEE IDENTIFICATION				
Civil ID / Passport #	Company ID #	Name		Position
74987986		Jaswinder Singh		
Nationality	Age	Sex	Company	Location
Indian	41	M	Touck Omar	

EXAMINATION TYPE		
<input type="checkbox"/> Pre-employment Examination (PRE)	<input type="checkbox"/> Periodic Medical Examination (PME)	<input type="checkbox"/> Post-absence Examination
<input type="checkbox"/> Change of Position Examination	<input type="checkbox"/> Exit Examination	<input type="checkbox"/> Critical Activities Examination
<input type="checkbox"/> Emergency Response Team	<input type="checkbox"/> Traveling Examination	

Medical Suitability for Work	
Medical Suitability for Work	<input checked="" type="checkbox"/> Fit to work <input type="checkbox"/> Fit with following restrictions <input type="checkbox"/> Pending Fitness <input type="checkbox"/> Not fit to work



### Restrictions

<input type="checkbox"/> Working at height	<input type="checkbox"/> Pulling, pushing or carrying weight
<input type="checkbox"/> Working in confined space	<input type="checkbox"/> Ascend/descend ladders and stairs
<input type="checkbox"/> Working with electricity	<input type="checkbox"/> Walking or standing for long distance/period
<input type="checkbox"/> Working in extreme heat	<input type="checkbox"/> Repetitive movements
<input type="checkbox"/> Working near rotating machinery	<input type="checkbox"/> Operating cargo machinery
<input type="checkbox"/> Use of respirator	<input type="checkbox"/> Emergency response duty
<input type="checkbox"/> Driving vehicle	<input type="checkbox"/> Handling chemical products
<input type="checkbox"/> Flying	Other, specify: <input type="text"/>

Temporary Unfit Until:

New Position	New Function	New Department
NA	NA	NA

Examination Date	Exams Performed
03/10/2024	

Medical Review Date		Employee Signature
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Doctor Name	Medical License	Hospital	Medical Coordinator Signature



# MEDICAL & SURGICAL HISTORY QUESTIONNAIRE



CANDIDATE / EMPLOYEE IDENTIFICATION					
CNS ID / Passport #		Company ID #		Name	
74981886				Jaswinder Singh	
Nationality		Age		Company	
Indian		41		Touck Oman	
Sex		Location			
M					

## PERSONAL HEALTH HISTORY

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

Disorders of the heart or circulation (i.e. chest pain, heart murmurs)	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Skin disorders e.g. severe acne, dermatitis, eczema or allergy	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
High blood pressure	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Eat, nose or throat problems	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Palpitations (i.e. being aware of the heart beats)	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Allergies e.g. dust, medication, bee sting	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Lung disease e.g. bronchitis, asthma, dyspnea, T.B	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Kidney or bladder disease e.g. recurrent infection, renal stones	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Phlegm productions or tight chest	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Sexually transmitted disease	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Blackouts, dizziness, fainting, memory loss, uncoordinatedness (vertigo/vynose)	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Is your eyesight satisfactory	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Nervous disorder, or emotional breakdown, depression, anxiety	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Is your hearing satisfactory	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Epilepsy / Seizures	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Do you wear glasses or contact lenses	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Recurrent headaches or migraines	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Do you have color blindness	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Any sleep problems	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Do you have any phobia from working at heights	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Foot deformities or problems	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Do you have any phobia from working at confined spaces	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Muscle problems e.g. weakness of your limbs or twitchy muscles	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Experienced weight loss or gain > 5kg over the past year	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Joint problems, e.g. plantar warts, joint pain or swelling	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Informed about being overweight or obese	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Problems with limb, neck or spine mobility	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Treated for malaria	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Experienced back problem, sprain, slipped disc	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Treated for depression, stress	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Disorders of the digestive tract e.g. ulcers, recurrent diarrhea, gall stones	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Treated for substance abuse	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Rectal bleeding, jaundice	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Received counseling or treatment for HIV/AIDS	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Diabetes or any other glandular diseases	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Received counseling or treatment for Hepatitis	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Cancer, growth or tumor of any kind	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Anemia, especially Sickle Cell Disease or Sickle Cell Trait or Thalassemia	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Frequent headache	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	GBPD (Glycemia)	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Pain in neck or back or hands or legs	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Any other diseases not mentioned in the above list?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> 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

Date: 03.10.2024

List any previous injuries or operations

Previous injuries or operations	Date
nil	

Candidate/Employee Signature

*JA*



# SCREENING QUESTIONNAIRE



CANDIDATE / EMPLOYEE IDENTIFICATION				
Civil ID / Passport #	Company ID #	Name		Position
7498798		Jaswinder Singh		
Nationality	Age	Sex	Company	Location
Indian	41	M	Truck Oper	

**FAGERSTROM TEST**

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

How soon after waking up do you smoke your first cigarette?  >60min  31-60min  6-30min  <5 minutes

Do you find it difficult to avoid smoking where it 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 feel 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 hrs 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?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	11. Is your digestion not good?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
2. Do you find it hard to like your daily work?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	12. Do you have unpleasant sensations in your stomach?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
3. Do you find difficult taking decisions?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	13. Do you get scared easily?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
4. Is your daily work a suffering?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	14. Do you feel nervous, tense or worried?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
5. Do you feel tired all the time?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	15. Do you feel unhappy?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
6. Are you easily tired?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	16. Do you cry more than usual?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
7. Do you have frequent headaches?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	17. Has the thought or emotion you are been on your mind?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
8. Do you feel lack of hunger?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	18. Do you find it difficult to perform your work?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
9. Do you sleep badly?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	19. Have you lost interest in things?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
10. Do your hands tremble?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	20. Do you feel you're worthless?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No

Date: 03/10/2021

Candidate/Employee Signature

*[Signature]*

*[Stamp]*

# RESPIRATORY PROTECTION QUESTIONNAIRE



CANDIDATE / EMPLOYEE IDENTIFICATION					
Civil ID / Passport #		Company ID #		Name	
74951956				Jaswinder Singh	
Nationality	Age	Sex	Company		Location
Indian	41	M	Truck Driver		

## RESPIRATORY PROTECTION MEDICAL EVALUATION QUESTIONNAIRE - OSHA

Do you use a respirator?  YES  NO What type:  Disposable mask  Cartridge 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. Atelectasis  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 k. 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 interferes with your use of a respirator  
 YES  NO c. Anxiety  YES  NO

Date: 03.10.2024



# HEARING CONSERVATION QUESTIONNAIRE



CANDIDATE / EMPLOYEE IDENTIFICATION				
Civil ID / Passport #	Company ID #	Name		Position
14989166		Jaswinder Singh		
Nationality	Age	Sex	Company	Location
Indian	41	M	Tack Omar	

## 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:

<input checked="" type="checkbox"/> Hunting	<input checked="" type="checkbox"/> Car races	<input checked="" type="checkbox"/> Sport shooting	<input checked="" type="checkbox"/> Woodwork	<input checked="" type="checkbox"/> Target shooting
<input checked="" type="checkbox"/> Power tools	<input checked="" type="checkbox"/> Mower	<input checked="" type="checkbox"/> Concerts / Band	<input checked="" type="checkbox"/> Welding	<input checked="" type="checkbox"/> Air compressor
<input checked="" type="checkbox"/> Construction	<input checked="" type="checkbox"/> Scuba diving	<input checked="" type="checkbox"/> 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:

<input checked="" type="checkbox"/> Ear Fullness	<input checked="" type="checkbox"/> Ear Infections	<input checked="" type="checkbox"/> Ear Surgery	<input checked="" type="checkbox"/> Head Injury	<input checked="" type="checkbox"/> Chemotherapy
<input checked="" type="checkbox"/> Ringing in the ears	<input checked="" type="checkbox"/> Ear Pain	<input checked="" type="checkbox"/> Earwax buildup	<input checked="" type="checkbox"/> Intravenous Antibiotics	<input checked="" type="checkbox"/> Hole in the Eardrum
<input checked="" type="checkbox"/> Ear Drainage	<input checked="" type="checkbox"/> Dizziness			

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

<input checked="" type="checkbox"/> Meningitis	<input checked="" type="checkbox"/> Diabetes	<input checked="" type="checkbox"/> Measles	<input checked="" type="checkbox"/> Syphilis	<input checked="" type="checkbox"/> Chickenpox	<input checked="" type="checkbox"/> Mumps	<input checked="" type="checkbox"/> Chronic ear infections
<input checked="" type="checkbox"/> Hypertension	<input checked="" type="checkbox"/> Renal Failure	<input checked="" type="checkbox"/> Tuberculosis	<input checked="" type="checkbox"/> Previous surgery	<input checked="" type="checkbox"/> Thyroid Problems	<input checked="" type="checkbox"/> Trauma to head/ ear canal / tympanic membrane	

5 - Check ALL that you are currently suffering from:

<input checked="" type="checkbox"/> Sinusitis	<input checked="" type="checkbox"/> Cold/Flu	<input checked="" type="checkbox"/> Ear infection	<input checked="" type="checkbox"/> Allergic rhinitis
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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 descent  Army  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  Motorcycle  Walking

Date: 3/10/2024



Candidate/Employee Signature

*[Handwritten Signature]*

RECEIVED

# PHYSICAL ASSESSMENT FORM



CANDIDATE / EMPLOYEE IDENTIFICATION					
Civil ID / Passport #	Company ID #	Name		Position	
7495786		Jaswinder Singh			
Nationality	Age	Sex	Company	Location	
Indian	41	M	Truck Owner		

VITAL SIGNS					
Height	184 cm	Weight	97 Kg	BMI	28.6
Pulse	54 min	Medical Practitioner Name			Signature

VISUAL SYSTEM						
Visual Acuity Test	Right Uncorrected: 6/6	Left Uncorrected: 6/6	Right Corrected:	Left Corrected:	Both Uncorrected: 6/6	Both Corrected:
Colour Vision Test (Ishihara)	# of Plates passed: 13/14	Inform the Plates # Failed:	<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Visual Field Test: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Stereoscopic Vision Test: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Date of Examination:	3/10/24		Medical Practitioner Name:			Signature:

RESPIRATORY SYSTEM						
<b>[1] Spirometry Test</b>						
Smoking Status:	<input checked="" type="checkbox"/> Never	<input type="checkbox"/> Ever Used	<input type="checkbox"/> Current	Patient's Posture During Test:	<input type="checkbox"/> Standing	<input checked="" type="checkbox"/> Sitting
Diagnoses:	<input type="checkbox"/> Asthma <input type="checkbox"/> COPD <input type="checkbox"/> Other					
Acceptability Criteria (per cent of which applies)		Acceptability Criteria (per cent of which applies)				
<input checked="" type="checkbox"/> Free from artifacts <input checked="" type="checkbox"/> Good start <input type="checkbox"/> Satisfactory exhalation <input type="checkbox"/> NOT satisfactory		<input checked="" type="checkbox"/> acceptable curves FEV1 values AND PVC values within 0.15L (150 ml) <input type="checkbox"/> Total of THREE to EIGHT tests performed <input type="checkbox"/> The patient CAN NOT or SHOULD NOT continue				
The Patient Demonstrated:	<input checked="" type="checkbox"/> Good Effort <input type="checkbox"/> Difficultly following instructions <input type="checkbox"/> Ability to sustain only one good effort <input type="checkbox"/> Poor Effort <input type="checkbox"/> Cooperation					
Date of Examination:	3/10/24		Medical Practitioner Name:	Signature:		

<b>[2] Chest Shape and Movement</b>		<b>[3] Chest Percussion</b>		
<input checked="" type="checkbox"/> Normal	If abnormal, describe below:	<input checked="" type="checkbox"/> Normal	If abnormal, describe below:	
<input type="checkbox"/> Abnormal		<input type="checkbox"/> Abnormal		
<input type="checkbox"/> Not Examined		<input type="checkbox"/> Not Examined		
<b>[4] Air Entry in Both Lungs</b>		<b>[5] Breath sounds</b>		
<input checked="" type="checkbox"/> Normal	If abnormal, describe below:	<input checked="" type="checkbox"/> Normal	If abnormal, describe below:	
<input type="checkbox"/> Abnormal		<input type="checkbox"/> Abnormal		
<input type="checkbox"/> Not Examined		<input type="checkbox"/> Not Examined		
Date of Examination:	3/10/24		Physician Name:	Signature:

ENT SYSTEM					
<b>[1] Otolscopy</b>			<b>[2] Hearing Test</b>		
Ear Canal Collapse	Right: <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Exam	Left: <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Exam	Eardrum Position	Right: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Retracted <input type="checkbox"/> Bulging <input type="checkbox"/> Not Exam	Whisper Test: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Exam
Drainage	Right: <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Exam	Left: <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		Left: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Retracted <input type="checkbox"/> Bulging <input type="checkbox"/> Not Exam	Rinne Test: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Exam
Pertization	Right: <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Exam	Left: <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Exam	Eardrum Vascularity	Right: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Considerable <input type="checkbox"/> Mtd <input type="checkbox"/> Not Exam	Weber Test: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Exam
Concomit	Right: <input checked="" type="checkbox"/> None <input type="checkbox"/> Some	Left: <input checked="" type="checkbox"/> None <input type="checkbox"/> Some		Left: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Considerable <input type="checkbox"/> Mtd <input type="checkbox"/> Not Exam	Adometry Done: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
			Audiologist Name:	Hearing Questionnaire filled: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
			Signature:		



**DEPARTMENT OF LABORATORY MEDICINE**
**File No:** 50126383  
**Name:** JASWINDER SINGH 7170

**Report No:** 0133044  
**Sample Date:** 03/10/2024 **Time:** 9:14

**Address:**  
**Gender:** M **Age:** 41 Y **Nationality:** INDIAN

**Received By:**  
**Received Date:** **Time:**  
**Report Date:** 03/10/2024 **Time:** 13:38

**GSM No.:** 96155670 **ID Card No.:** 74987986  
**Ref. By:** DR SIKANDAR KHAN

**Bill No:** 0328210 **Bill Date:** 03/10/2024

INVESTIGATION	RESULT	REFERENCE RANGE
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OQ FTW PACKAGE-3 for Drivers and Operators (Below 49 yrs)

**COMPLETE BLOOD COUNT**

 TOTAL WBC COUNT 6.37 x 10<sup>3</sup> /  $\mu$ L 4.00-11.00 x 10<sup>3</sup> /  $\mu$ L

**DIFFERENTIAL COUNT**

NEUTROPHIL (%)	44.27 %	40-75%
LYMPHOCYTE (%)	37.78 %	20-45%
MONOCYTE (%)	7.48 %	2-8%
EOSINOPHIL (%)	8.24 %	1-6%
BASOPHIL (%)	2.24 %	0-1%

HAEMOGLOBIN	14.96 gm/dl	Male : 13 -18 gm/dl Female:11-15 gm /dl childrens upto 1year-11.0 - 13.0 gm /dl upto 12years-11.5 - 14.5 gm /dl cord blood:13 -19.5 gm /dl
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RBC COUNT	5.27 million/cu	Male :4.5-6.5 million/cu Female:3.9-5.5 million/cu
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PLATELET COUNT	358.90 x 10 <sup>3</sup> / $\mu$ L	150 - 400 x 10 <sup>3</sup> / $\mu$ L
----------------	------------------------------------	---------------------------------------

HEMATOCRIT	46.12 %	Male :42 - 52% Female:37 - 47%
------------	---------	-----------------------------------

MCV	87.58 fl	76 - 96 fl
-----	----------	------------

MCH	28.41 pg	27 - 33 pg
-----	----------	------------

MCHC	32.44 gm/dl	32 - 36 gm/dl
------	-------------	---------------

**URINE ROUTINE**
**URINE BIOCHEMISTRY**

URINE GLUCOSE	NEGATIVE	NEGATIVE
---------------	----------	----------

Verified By:

Approved By:



10589

Lab Technologist

Specialist Pathologist

 MOH License No: 17975  
 Electronically signed at: 10/3/2024 1:40:00

Printed at: 03/10/2024 1:54:10 PM

Page : 1 of 4


 NMC Healthcare, LLC  
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DEPARTMENT OF LABORATORY MEDICINE

File No: 50126383	Report No: 0133044
Name: JASWINDER SINGH 7170	Sample Date: 03/10/2024 Time: 9:14
Address:	Received By:
Gender: M Age: 41 Y Nationality: INDIAN	Received Date: Time:
GSM No.: 96155670 ID Card No.: 74987986	Report Date: 03/10/2024 Time: 13:38
Ref. By: DR SIKANDAR KHAN	Bill No: 0328210 Bill Date: 03/10/2024

INVESTIGATION	RESULT	REFERENCE RANGE
URINE PROTEIN	NEGATIVE	NEGATIVE
URINE KETONE	NEGATIVE	NEGATIVE
URINE BILIRUBIN	NEGATIVE	NEGATIVE
NITRITE	NEGATIVE	NEGATIVE
URINE PH	8.0	4.6-8.0
SPECIFIC GRAVITY	1.010	1.010-1.030
BLOOD	NEGATIVE	NEGATIVE
UROBILINOGEN	NORMAL	NORMAL
URINE MACROSCOPY		
COLOUR	PALE YELLOW	
APPEARANCE	CLEAR	
URINE MICROSCOPY		
RBC	NIL /hpf	0-3
PUSCELLS	2-3 /hpf	0-5
EPITHELIAL CELLS	0-2 /hpf	NIL
CRYSTAL	NIL /hpf	NIL
CAST	NIL /hpf	NIL
BACTERIA	NIL	NIL
MUCOUS THREAD	NIL	NIL
FASTING BLOOD SUGAR	4.76 mmol/L	4.11 - 6.05 mmol/L
BLOOD GROUP & RH TYPING	"B" Rh POSITIVE.	

Confirmation of the Newborn's blood group is indicated when the "A" and "B" antigen expression and the isoagglutinins are fully developed (2-4 years).

Verified By:

Approved By:



10589

Lab Technologist

Specialist Pathologist

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**DEPARTMENT OF LABORATORY MEDICINE**

<b>File No:</b> 50126383	<b>Report No:</b> 0133044
<b>Name:</b> JASWINDER SINGH 7170	<b>Sample Date:</b> 03/10/2024 <b>Time:</b> 9:14
<b>Address:</b>	<b>Received By:</b>
<b>Gender:</b> M <b>Age:</b> 41 Y <b>Nationality:</b> INDIAN	<b>Received Date:</b> <b>Time:</b>
<b>GSM No.:</b> 96155670 <b>ID Card No.:</b> 74987986	<b>Report Date:</b> 03/10/2024 <b>Time:</b> 13:38
<b>Ref. By:</b> DR SIKANDAR KHAN	<b>Bill No:</b> 0328210 <b>Bill Date:</b> 03/10/2024

INVESTIGATION	RESULT	REFERENCE RANGE
<b>LIPID PROFILE</b>		
TOTAL CHOLESTEROL	4.97 mmol/L	< 5.18 mmol/L
HDL	1.30 mmol/L	>1.5 mmol/L
TRIGLYCERIDES	1.39 mmol/L	Desirable : <2.083 mmol/L Boderline high : 2.83 - 5.67 mmol/L Hypertriglyceridemia >5.65 mmol/L
LDL	3.30 mmol/L	< 2.6 mmol/L
VLDL	0.63 mmol/L	0.128-0.645mmol/L
<b>LIVER FUNCTION TEST</b>		
TOTAL BILIRUBIN	19.00 µ mol/L	Adults:- up to 21 µ mol/L, Children >1 month - up to 17 µ mol/L, Neonates :- 1.7 - 180 µmol/L
DIRECT BILIRUBIN	4.80 µ mol/L	Adults :- 0 - 5.0 µ mol/L, Neonates:- 0-10 µ mol/L,
TOTAL PROTIEIN	72.10 g/L	Adults : 65 - 87 g/L
ALBUMIN	43.60 g/L	39.7 - 49.4 g/L
Globulin	28.5 g/L	23-35g/L
SGOT (AST)	29.80 U/L	MALE : up to 40 U/L, FEMALE : up to 32 U/L.
SGPT (ALT)	31.60 U/L	MALE : up to 41 U/L, FEMALE : up to 33 U/L.
ALKPO4 (ALP)	60.00 U/L	Adults: MALES: 40 - 129 U/L, FEMALES: 35 - 104 U/L.
Gamma GT (GGT)	25.00 U/L	MALE- 8 - 61 U/L, FEMALE- 5 - 36 U/L

**Verified By:**
**Approved By:**

**10589**
**Lab Technologist**
**Specialist Pathologist**

MOH License No: 17976

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Page : 3 of 4


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**DEPARTMENT OF LABORATORY MEDICINE**

<b>File No:</b> 50128383	<b>Report No:</b> 0133044		
<b>Name:</b> JASWINDER SINGH 7170	<b>Sample Date:</b> 03/10/2024	<b>Time:</b> 9:14	
	<b>Received By:</b>		
<b>Address:</b>	<b>Received Date:</b>	<b>Time:</b>	
<b>Gender:</b> M <b>Age:</b> 41 Y <b>Nationality:</b> INDIAN	<b>Report Date:</b> 03/10/2024	<b>Time:</b> 13:38	
<b>GSM No.:</b> 98155670 <b>ID Card No.:</b> 74987986	<b>Bill No:</b> 0328210	<b>Bill Date:</b> 03/10/2024	
<b>Ref. By:</b> DR SIKANDAR KHAN			

INVESTIGATION	RESULT	REFERENCE RANGE
<b>RENAL FUNCTION TEST</b>		
URIC ACID	371.00 $\mu$ mol/L	MALE: 202.3 - 416.5 $\mu$ mol/L, FEMALE: 142.8 - 339.2 $\mu$ mol/L
CREATININE	97.00 $\mu$ mol/l	Adults: MALE: 62 - 106 $\mu$ mol/L FEMALE: 44 - 80 $\mu$ mol/L
UREA	4.30 mmol/L	2.76 - 8.07 mmol/L
SICKLE CELL	NEGATIVE.	
Method : Solubility test ( If Positive , Hb Electrophoresis / HPLC to be done to confirm Sickle cell anaemia / Trait).		

**Verified By:**

**10589**
**Lab Technologist**

 MOH License No: 17976  
 Electronically signed at: 10/3/2024 1:40:00

**Approved By:**

**Specialist Pathologist**

 مستشفى أن أم نسي التخصصي  
**nmc specialty hospital**

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Page : 4 of 4

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### nmc specialty hospital, al-hail

P.O BOX : 613, Postal Code : 133 al-hail Sultanate of Oman

SI No: 39186	Bill Date: 03/10/2024	Report Date :03/10/2024 12:16:45
Patient Name: JASWINDER SINGH 7170	Reg No: 50126383	
Age: 41Y	Gender: Male	Nationality: INDIA
Address:		
Company: TRUCKOMAN EQUIPMENT RENTAL LLC	Policy No:	
Certificate No:		
Region: LUMBAR SPINE AP & LAT		
Referred Doctor:	Consultant Name: DR SIKANDAR KHAN	

#### LUMBAR SPINE AP & LAT VIEWS

Vertebral bodies & disc spaces are normal.  
 Posterior elements appear normal.  
 Para vertebral soft tissue appears normal.  
 No obvious fracture seen.

#### Suggested clinical correlation



**DR. ANAMIKA CHATURVEDI**  
 Specialist - Radiology  
 MOH Lic. No: 1709  
 nmc specialty hospital, Al Hail

**DR ANAMIKA CHATURVEDI**

**Radiology**

03/10/2024 12:16:39

Disclaimer : This is an electronically generated report and does not require a doctor's signature

Elvgent Medical Center LLC

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C.R.No: 1668187, Tax Card No: E1481179 VATIN: OM1100027111

# AUDIOMETRY REPORT

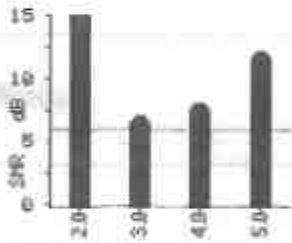
Name of the Patient JASWINDER SINGH

Age 41 yrs Sex M MRN 50126383 Date of Test 3/10/2024

U107.05  
03-OCT-24 10:49  
DP 2s 2 sec avg  
SN: G11005649 G12014595

NAME: \_\_\_\_\_

Left: Pass

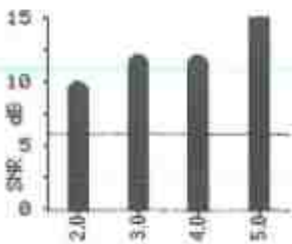


F2	L1	L2	DP	NF	SNR	
2.0	65	55	3	-13	17	P
3.0	67	55	-11	-18	7	P
4.0	63	54	-11	-19	8	P
5.0	63	54	-8	-20	12	P

U107.05  
03-OCT-24 10:48  
DP 2s 2 sec avg  
SN: G11005649 G12014595

NAME: \_\_\_\_\_

Right: Pass



F2	L1	L2	DP	NF	SNR	
2.0	65	58	1	-9	10	P
3.0	65	58	-7	-20	12	P
4.0	65	58	-6	-18	12	P
5.0	66	58	1	-20	21	P



Signature of the Technician

NMCOMAN/DOC/NSG/75



**Pulmonary Function Report**

**Subject Information**

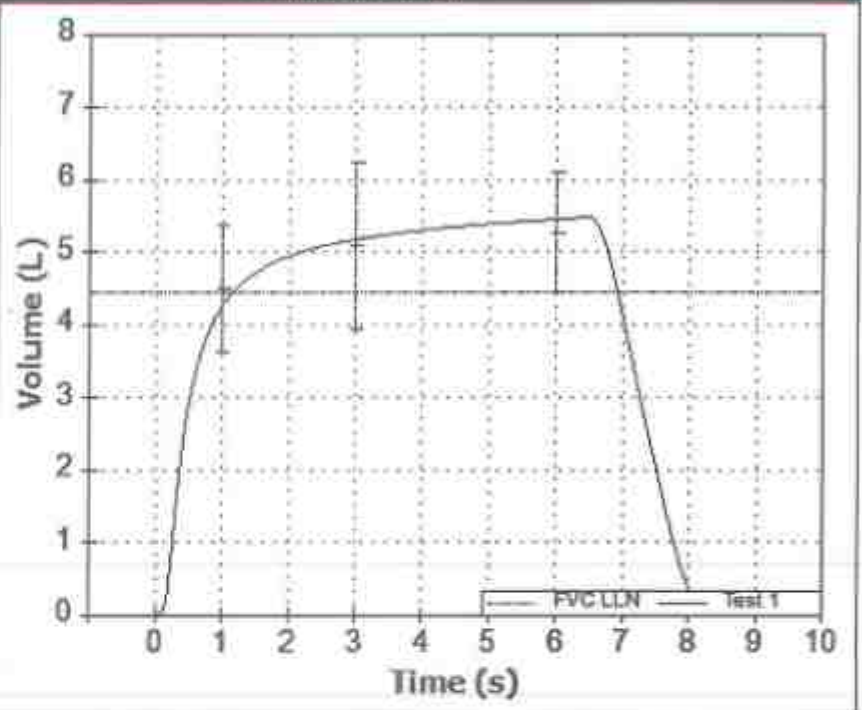
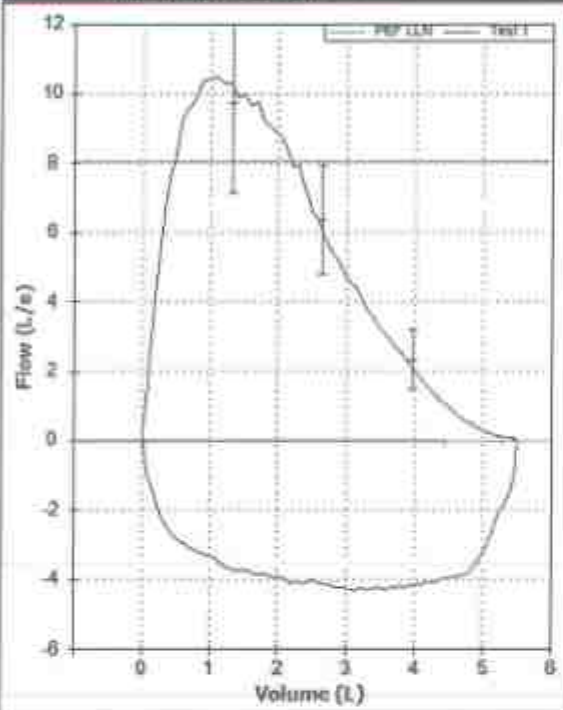
ID:	2024277_101356058	Alternate ID:	50126383	Middle Name:	
Last Name:	Singh	First Name:	Jaswinder	Date of Birth:	15/05/1983
Population:	MIDDLE EAST	Gender:	Male	Weight:	97.0 kg
Age:	41	Height:	181 cm		
BMI:	28.7	Smoking:	Non Smoker		

**Test Session Information**

Test Date:	03/10/2024 10:15	Device:	ALPHA Touch	Serial Number:	32166
No. of Tests:	5	Accuracy Chk:	30/05/2019 15:42	User:	Administrator
Pred. Values:	Golshan	Pred. Factor:	100%	Posture:	Sitting

**Flow/Volume Graph**

**Volume/Time Graph**



**Results**

Parameter	Pred	LLN	Best	% Pred.	Z-Score
FVC (L)	5.27	4.44	5.48	104	0.41
FEV1 (L)	4.50	3.64	4.45	99	-0.10
FEV1 Ratio	0.80	0.68	0.81	101	0.14
FEV6 (L)	5.27	4.44	5.47	104	0.40
PEF (L/min)	667	484	630	94	-0.33
FEF25-75 (L/s)	5.14	3.99	4.48	87	-0.94

Values at BTPS, \*Below lower limit of normality (LLN)

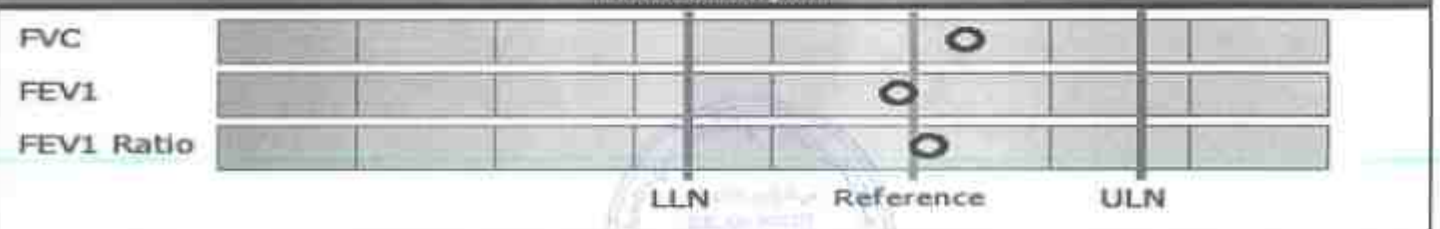
**Session Quality and Repeatability Information**

FVC Session Grade	FVC Rep:	FEV1 Rep:	Slow Start of test	End of test criteria not achieved	Cough detected in 1st second
D	-	-	0 blow(s)	0 blow(s)	0 blow(s)

**Computer Suggested Interpretation**

Computer interpretations cannot be relied upon for diagnosis. Normal ventilatory function.

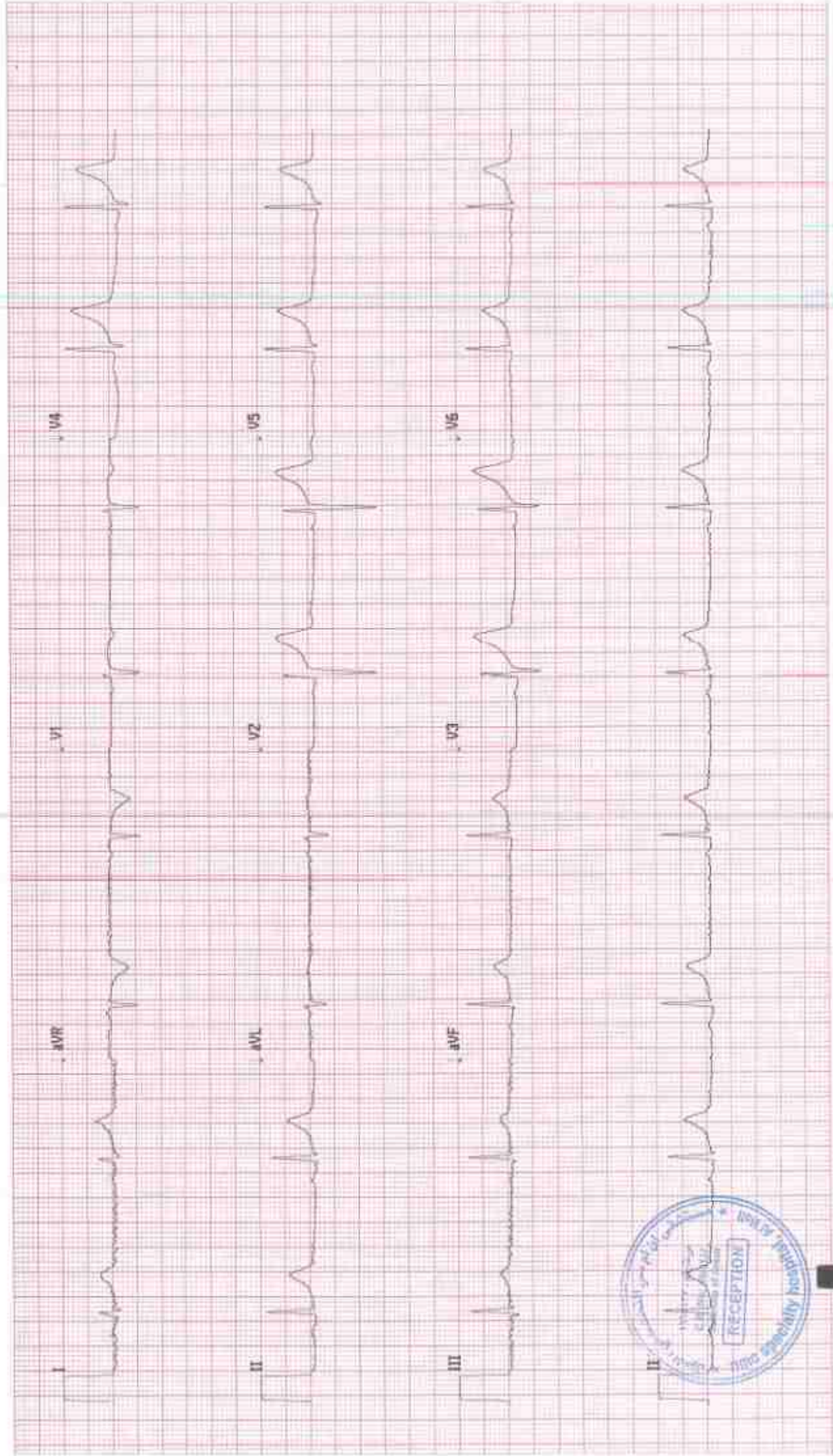
**Reference Pictogram**



ID: S0126383  
DOB: 39yr. Male

Vent rate: 47 BPM  
PR int: 169 ms  
QRS dur: 92 ms  
QT/QTc: 437/399 ms  
P-R-T axes: 45 76 47

SINUS BRADYCARDIA  
BORDERLINE ECG  
UNCONFIRMED REPORT



Jasvinder Singh

Drugs & Diseases > Calculators

Calculator	About	References	Default Units
<h2>Framingham Risk Score (2008)</h2>			<input type="checkbox"/> Copy Results
<h3>Questions</h3>			<b>Results</b>
1. Gender?	Male		Estimated 10-year Global CVD Risk
2. Age?	40-44		<b>2.8%</b>
3. Total Cholesterol?	4.14-5.15 mmol/L		Risk Category
4. HDL?	1.30-1.55 mmol/L		<b>Low Risk</b>
5. Systolic Blood Pressure?	<120 mmHg		Estimated Vascular Age
6. On Medication for Hypertension?	No		<b>36 Years</b>
7. Smoker?	No		Treatment Guidelines
8. Diabetic?	No		<b>ATP-III (2004)</b> Treatment Targets LDL <160 mg/dL (<4.14 mmol/L) Non-HDL <190 mg/dL (<4.93 mmol/L)
9. Known Vascular Disease (CAD, PVD, S...)	No		<b>CCS (2009)</b> Initiate Pharmacotherapy if LDL >5 mmol/L (>193 mg/dL) TChol/HDL-C >6 mmol/L (>231 mg/dL)
<h3>About</h3> <p>The FRS estimates the 10 year risk of manifesting clinical CVD (CAD, Stroke, PVD, CHF, cardiac death). Although not examined in the 2008 model, it is common practice to double the FRS if there is a FHx of premature CAD in a 1st degree relative (men &lt;55y, women &lt;65y).</p> <p>*The risk stratification tool for the ESC is the SCORE system which estimates 10y risk of CVD death. Patients with a 10y risk of CVD death <math>\geq 5\%</math> are considered high risk. The lipid guidelines recognize risk equivalents as a distinct category that warrant immediate treatment. For patients with an ESC SCORE <math>\geq 5\%</math> a 3 month trial of lifestyle measures is a reasonable starting point. If after 3 months the lipids remain above moderate risk targets and the SCORE remains <math>\geq 5\%</math> then intensive therapy to reach high risk targets is recommended.</p>			<b>Treatment Targets</b> $\geq 50\%$ decrease in LDL-C
			<b>ESC (2007, see info for more)</b> Treatment Targets LDL <3 mmol/L (<120 mg/dL) TChol <5 mmol/L (<194 mg/dL)

Created by QxMD

## References

Ralph B. Di&agrave;Agostino, Sr, Ramachandran S. Vasan, Michael J. Pencina, Philip A. Wolf, Mark Cobain, Joseph M. Massaro and William B. Kannel.

General cardiovascular risk profile for use in primary care: the Framingham Heart Study.

Circulation 2008 February 12, 117 (6): 743-53

McPherson R et al.

Canadian Cardiovascular Society position statement—recommendations for the diagnosis and treatment of dyslipidemia and prevention of cardiovascular disease.

Canadian Journal of Cardiology 2006, 22 (11): 913-27

Management of Blood Cholesterol in Adults: Systematic Evidence Review from the Cholesterol Expert Panel.

Ian Graham et al.

European guidelines on cardiovascular disease prevention in clinical practice: executive summary: Fourth Joint Task Force of the European Society of Cardiology and Other Societies on Cardiovascular Disease Prevention in Clinical Practice (Constituted by representatives of nine societies and by invited experts).

European Heart Journal, Volume 28, Issue 19, October 2007, Pages 2375-2414

The Framingham Risk Score (2008) calculator is created by QxMD.



**SULTANATE OF OMAN** سلطنة عُمان  
 Royal Oman Police  
 (Oman's Council of Traffic) وزارة الداخلية للشرطة  
 ROAD DRIVING LICENCE رخصة قيادة مركبة



**LICENCE NUMBER :** 74987986 : رقم الرخصة  
**ISSUE AT :** SUHAR : مكان الاصدار : صهار  
**FIRST ISSUED :** 2006/10/18 : الاصدار الاول :  
**EXPIRY DATE :** 2025/08/06 : تاريخ الانتهاء :  
 الاسم : جاسوندر سينغ

**NAME** JASWINDER SINGH  
 سلطة ترخيص  
 L.A.V./HONRY



**NATIONALITY :** INDIAN الجنسية : هندي  
**DATE OF BIRTH :** 1983/05/16 تاريخ الميلاد :  
 العنوان : بوشهر  
**ADDRESS :** Bousher  
**BLOOD GROUP :** B POS فصيلة الدم : B موجب  
**LICENCE CLASS :** LIGHT VEH - HEAVY VEH فئة الرخصة : مركبة خفيفة - مركبة ثقيلة  
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