

Initial Medical Examination Report

INITIAL EXAMINATION REPORT (MEDICAL - CONFIDENTIAL)

Place of examination: Aster Hospital, Ibri		Date: 21/2/2024	Surname: THOTTI Forenames: A SHRAF Address: 1B/1																																																													
If a dependant enter employee's name here:		Project:																																																														
Birth date: 30/4/1959	Nationality: Indian	Country of birth:		Religion:																																																												
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced	<input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter		Number of children:																																																												
Reason for examination	Pre-Employment <input type="checkbox"/> Job: Pre-Overseas <input type="checkbox"/> Area:																																																															
Name and address of family doctor	List your last 3 jobs (1)																																																															
Are you a Registered Disabled Person? (UK only) <input type="checkbox"/>	Do you belong to any Medical Insurance Scheme? <input type="checkbox"/>																																																															
DO YOU HAVE OR HAVE YOU HAD:- (Tick "Yes" or "No" column or put a (?) if uncertain exclude minor ailments.)																																																																
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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																																																																
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PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT:- I declared these statements to be true to the best of my knowledge and belief and I agree that the result of this medical examination in general terms may be revealed to the Company if required, and the details sent to my own doctor if this is considered necessary by the examining medical officer. I am also aware that PDO reserve the right to dismiss me if it was found that I have purposely withheld important medical information.																																																																
Date: 21/02/2024	Signature of Applicant:																																																															

FOR COMPLETION BY EXAMINING DOCTOR OR NURSE
Further details of medical history and recreational activities

N = Normal A = Abnormal (please describe)		PHYSICAL EXAMINATION										
N	A											
		1. Eyes & Pupils										
		2. E.N.T.										
		3. Teeth & Mouth										
		4. Lungs & Chest										
		5. Cardiovascular System										
		6. Abdo. Viscera										
		7. Hernial Orifices										
		8. Anus & Rectum										
		9. Genito-urinary										
		10. Extremities										
		11. Musculo-skeletal										
		12. Skin & Varicose Vns.										
		13. C.N.S.										

HEIGHT cm	WEIGHT kg	BMI	B.P.	PULSE 72/mins.	HEARING L R	VISION			Colour Vision	Blood Group
						DISTANT		NEAR		
167 cm	76 kg	27.3	150/90			R	L	R	L	Uncorrected 6/6 6/6
										Corrected

N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS		N	A			
						7. Audiogram		
✓						8. Lung Function		
✓							9. Chest X-Ray	
✓							10. ECG	
✓							11. CVS risk for 40 yrs. & above	
✓							12. HIV, Hepatitis screening	

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

Type 2 DM TAB METFORMIN 500mg 1-00 x 10 AF
Hypertension. TAB AMLODIPINE 5mg 1-00 x 10 AF

ASSESSMENT:

FIT ALL AREAS

FIT WITH RESTRICTION

TEMPORARY UNFIT

UNFIT

Blood pressure
monthly &
Blood sugar
monitoring

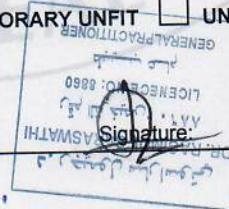
Date: 22/2/21

Name (Block Capitals): Dr. R. Aest

Date:

Name (Block Capitals): Dr.

REVIEW/CONSULTATION



Signature:

Metformin 500mg 1-00
Amloclipt 5mg 1-00
Rosas 100 0-01



Oman Al Khair Hospital LLC

P.O. Box 400, P.C. : 511, Ibriz, Sultanate of Oman

Tel: + 968 2568 8075, Fax: +968 2568 8025

Email: oakh.ibri@asterhospital.com

www.asterhospital.com

A Unit of DM Healthcare LLC

مستشفى عمان الخير

ص.ب. ٤٠٠، الرمز البريدي ٥١١، عبري، سلطنة عمان

هاتف: +968 2568 8075، فاكس: +968 2568 8025

البريد الإلكتروني: oakh.ibri@asterhospital.com

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وحدة من مجموعة دموين للرعاية الصحية