



Asia Royal Hospital  
Medical Check Up  
FITNESS CERTIFICATE



Name : Mr. Ngi Min Khant  
Date of Birth : 19.06.1999  
Position : Mechanic

Fit for work



Unfit for work



Fit for work with the following described care



Suggestion(s) :


**FIT**

Physician Name : Dr. Aye Hsu Swe

Clinic : Asia Royal Check up

Date of Examination : 25/02/2025

Date of Expiry of Certificate : 24/02/2026

Signed :  **Dr. Aye Hsu Swe**  
SAMA - 30643

**Asia Royal Hospital**

No.14, Baho Street, Sanchaung Township

Yangon, Myanmar

Ph: 01-7538055, 09-778778885

(The above recommendations are made according to the best of our knowledge, history, Physical examination & investigation results)



# Asia Royal Hospital

## Medical Imaging Report



No. 14, Baho Road, Sanchaung Township, Yangon, Myanmar.  
Ph: 01-7538055, 09-778778885 (Telenor to Telenor Short Code - 8885)  
Website : [www.asiaroyalhospital.com](http://www.asiaroyalhospital.com)

Patient Name : KO NYI MIN KHANT  
Sex : M  
Refer Doctor : DR. Asia Royal  
Patient ID : HRN-0326736

Study Date : 25/02/2025  
Age : 25  
Modality : DX  
Ref; Number : 2502613731002233

### Chest X-ray (PA view)

Heart is normal in size and shape.

There is no active parenchymal lung lesion.

Hila and mediastinum are normal.

No pleural effusion.

**IMPRESSION : NAD**

Dr. Kyaw Myint  
MBBS: DMRD  
Senior Consultant Radiologist

This is a professional opinion and not a final diagnosis. The findings are dependent on equipment and please correlate with history, clinical findings and other investigations. Report used for medico-legal purposes by unauthorized persons is prohibited.

AR-MED-ANC-IMG-EX-001/1.0/15-02-2023/01-03-2023

Page 1 of 1

Ko Nyi Min Khant  
 10492  
 Age: 25  
 Date of birth: 19/06/1999  
 Report Date: 25/02/2025  
 Tester:

Asia Royal Hospital  
 No.14, Baho Street, Sanchaung Township,  
 Yangon Myanmar.  
 Tel: ( Hunt Line) 538055, Fax: 95-1-537296



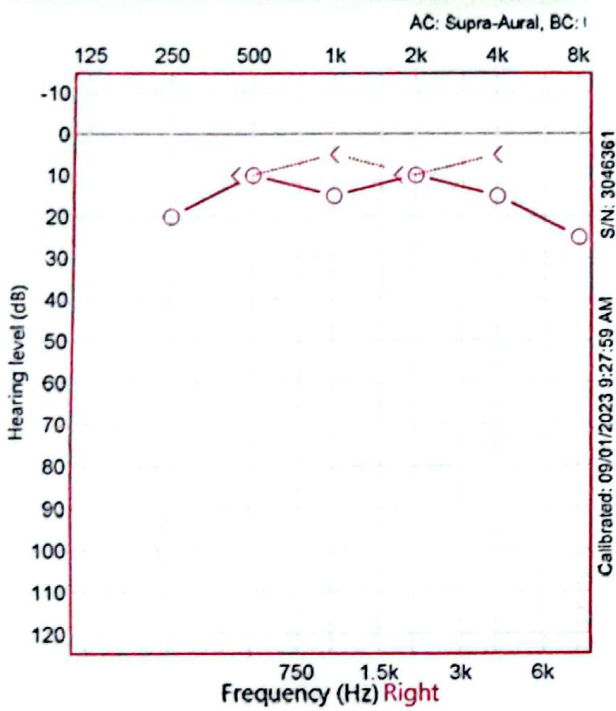
Report Comments:

**Audiometry:**

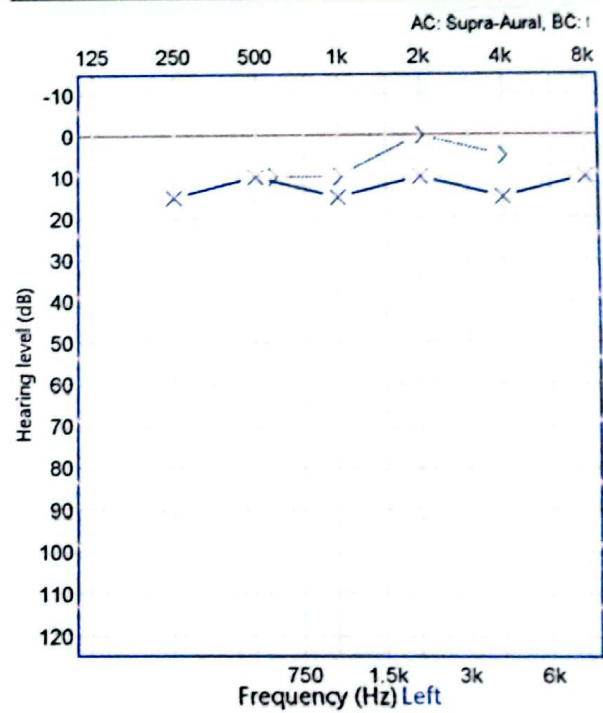
Right Ear -Normal

Left Ear -Normal

RIGHT 25/02/2025



LEFT 25/02/2025



**Legend**

L	R	Masked
X	O	AC □ △
>	<	BC J E
S	S	SF ✕ ∅
M	M	MCL
U	U	UCL
↘	↙	NR

PTA AC: 500, 1k, 2k  
 BC: 500, 1k, 2k  
 Aud Method:

**PTA (dB HL) / AI (%)**

	AC	BC	AI
Right	12	8	
Left	12	7	

Signed by:

\_\_\_\_\_



# ASIA ROYAL MEDICAL LABORATORY

ISO 9001  
2015  
Certified No. 685701

First Name: **KO NYI MIN KHANT**

Gender: **Male**

Diagnosis:

Age: 25 Year

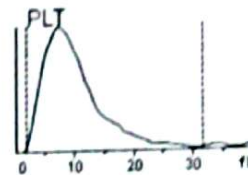
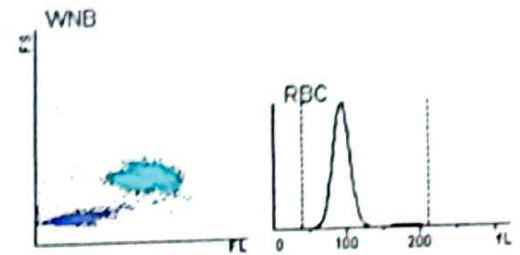
Refer Dr. DR. Asia Royal

Sample ID: 2502601170E

Patient ID:

Date of Analysis: 25-Feb-25 2:45 PM

Para.	Result	Unit	Ref. Ranges
1 WBC	7.79	10 <sup>3</sup> /uL	4.00 - 11.00
2 RBC	4.98	10 <sup>6</sup> /uL	4.50 - 6.50
3 HGB	14.0	g/dL	12.5 - 16.0
4 HCT	41.9	%	42.0 - 48.0
5 MCV	84.2	fL	76.0 - 96.0
6 MCH	28.1	pg	27.0 - 33.0
7 MCHC	33.4	g/dL	32.0 - 36.0
8 PLT	246	10 <sup>3</sup> /uL	150 - 400
9 RDW-SD	42.2	fL	37.0 - 54.0
10 RDW-CV	12.8	%	11.5 - 14.6
11 PDW	15.9		9.0 - 17.0
12 MPV	10.1	fL	7.4 - 10.5
13 P-LCR	24.8	%	13.0 - 43.0
14 P-LCC	61	10 <sup>9</sup> /L	30 - 90
15 PCT	0.248	%	0.170 - 0.350
16 NRBC%	0.00	/100WBC	
17 NRBC#	0.000	10 <sup>9</sup> /L	



Flag

**Dr. Khin Saw Aye / Daw**

Sr. Consultant Pathologist

M.B.,B.S., M.Med.Sc. (Pathology), Ph.D., FRCP (Glasg)

SAMA - 9832

Page 1

J



## LABORATORY REPORT

Patient's Name : KO NYI MIN KHANT Age & Sex : 25 Yrs / Male  
 Referral Doctor : DR. Asia Royal Hospital Reg. No. : HRN-0326736  
 Lab Ref. No. : 2502-601170 AD No./Room No. : 25-048633 /  
 Collected Date/Time : 25/02/2025 11:09 AM Reported Date : 25/02/2025  
 Sample Type : Blood Printed Date/ Time : 25/02/2025 06:39 PM

Test	Result	Unit	Reference Interval
<b>Lipid Profile</b>			
Cholesterol (Total)	3.92	mmol/L	< 5.2
	151	mg/dL	< 200
HDL Cholesterol	1.27	L mmol/L	>= 1.6
	49	L mg/dL	>= 62
LDL Cholesterol ( Direct )	2.61	mmol/L	< 3.3
	101	mg/dL	< 127
Triglycerides	0.56	mmol/L	< 1.7
	49	mg/dL	< 150
T.Chol/HDL Ratio	3.09		< 5
Uric Acid	231	μmol/L	202 - 417
Glucose	4.27	mmol/L	3.0 - 6.0 (Fasting)
		mmol/L	4.0 - 7.8 (Non-Fasting)
SGOT (AST)	23	U/L	< 50 (Male)
SGPT (ALT)	27	U/L	< 50 (Male)
Alkaline Phosphatase	57	U/L	40 - 130 (Male)
Urea	3.0	mmol/L	2.8 - 8.1
Creatinine	84	μmol/L	59 - 104 (Male)
eGFR (CKD-EPI)	115	mL/min/1.73 m <sup>2</sup>	>=60
(application to age >=18 yrs)			

8 Items Only

ဓာတ်ခွဲခန်းအဖြေများကိုသက်ဆိုင်ရာဆရာဝန်နှင့်သာတိုင်ပင်ပါရန်

Verified By : Daw May Thu Htet (Sr. Medical Laboratory Technologist)

Date : 25/02/2025 06 04 PM

Validated By : Dr. Aye Sanda Htun (Sr. Consultant Pathologist) M.B.,B.S.(Ygn) M.Med.Sc, Ph.D (Pathology)

Date : 25/02/2025 06 25 PM

This is a computer generated report. Results are validated electronically. Information contained in this document is confidential. The results reported herein have been in accordance with the terms of accreditation under the Singapore Accreditation Council. Duplication of this report is not allowed unless approved.

No. 14, Baho Road, Sanchaung Township, Yangon, Myanmar. Ph: 01-7538055, 09-778778885 (Telenor to Telenor Short Code - 888) (Ext: 2204),  
 Laboratory Ph: 09-443108416, E-mail : info.lab@asiaroyalhospital.com, Website : www.asiaroyalhospital.com

AR-LAB-QMS-EX-001/E-04/15-06-2023/21-06-2023/UNCONTROLLED



## URINE ANALYSIS REPORT

Sample ID : 2502601170      Doctor name : Asia Royal  
 Patient Name : Ko Nyi Min Khant      Bed No. :  
 Age : 25      Sample Number : 800061  
 Sex : Male      Received Date : 25/02/2025

UF 5000	Result	Reference	Unit
RBC	0.1	0-4	/HPF
Normal RBC	0.1	0-4	/HPF
WBC	0.1	0-4	/HPF
WBC Clumps	0.0	0-4	/HPF
EP cells	0.1	0-5	/HPF
Squa.EP	0.1	0-5	/HPF
Non-Squa EP	0.0	0-1	/HPF
Cast	0.00	0-1	/HPF
Hy.Cast	0.00	0-1	/HPF
Patho cast	0.00	0-1	/HPF
Bacteria	1.2	0-216	/HPF
Crystals	0.0	0-2	/HPF
Yeast cells	0.0	0-1	/HPF
Sperm	0.0	0-9	/HPF
Mucus	0.00	0-1	/HPF

UC 3500	Result	Unit
Chemistry		
Urobilinogen	normal	
BLD	-	
Bilirubin	-	
Ketone	-	
Glucose	-	
Protein	-	
pH	7.0	
Nitrite	-	
Leucocytes	-	
S.G	1.005	
Color	L YELLOW 01	
Turbidity	-	

(-) = Negative  
 (+ -) = Trace

Remark:

*Handwritten signature and date: 25/2/25*

**Dr. Khwar Nyo Zin**  
 Sr. Consultant Microbiologist  
 M.B.,B.S., M.Med.Sc. (Microbiology)  
 SAMA -9843

Analysis Time : 25/02/2025 14:58:47



AR-MED-ANC-WBC-RE-004

Edition : 1.0

Issue Date : 15-02-2023

Effective Date : 01-03-2023

- I hereby certify that the statements made by me below are true and correct to the best of my knowledge.
- I also give consent to the doctors of Asia Royal Hospital, for the physical examination and necessary investigational procedures for this medical examination.
- I hereby authorize Asia Royal Hospital to provide PTTEP (Company) with copies of all my medical records.

Date: 25/02/2025

Singature: \_\_\_\_\_  
 Name: KO NYI MIN KHANT  
 N.R.C No/Passport No: 5/TASANA(N)164435  
 Registration No: Ref-062537

To be completed on your own

Name	NRC No./ Passport No.	Member No.
KO NYI MIN KHANT	5/TASANA(N)164435	M02161
Father's Name U MIN MIN TUN	Job Title[Describe nature of work]	
Blood Group -	Identification Mark	
Permanent Address	FASTPOINT(PTTEP OUT PT)	
Phone No.	09984432353	

Sex  Male  Female Age:  Years Date of Birth : Day  Month  Year

Single  Separated  Widowed(er)  
 Married  Divorced  Number of children

Please tick the block under 'Yes' if you have the given symptom or 'No' if you don't have.

Past Medical History

Yes	No	Yes	No	Treated	Current
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



- Cholecystitis
- Hepatitis
- Depression
- Insomnia
- Blood in urine
- Any skin disease, if so

- Scabies
- Herpes
- Pustules
- Depigmentation
- Keloid
- Acute
- Chronic

- Sinusitis
- Joint/Back Problems, if so specify....
- BPH
- Malaria
- Filaria
- Typhoid
- Sexually transmitted disease, if so specify....

- Piles/Varicose Veins
- Any blood disease, e.g: Leukaemia, Thalassaemias, Anaemia, Haemophilia, G6PD Deficiency, if so specify...

Chief Complaint: Onshore checkup, no complaint

For Woman only

- Breast lump: Yes  No  if so specify...
- Regular menstruation: Yes  No  if not regular, describe in detail..
- LMP:
- Pregnant: 
  - Number of pregnancies:
  - First child:  years old
  - Last child:  years old
- Gynaecological problem & treatment: Yes  No  if so specify...

Personal History

- Do you take alcohol regularly? Yes  No  if so specify...
- Are you a smoker? Yes  No  Number of cigarettes per day:
- Are you an ex-smoker? Yes  No  How long have you been quitting smoking?
- Regular exercise: Yes  No

Hospitalization History

- Yes  No  if so specify...

**Vaccination History**

if so specify...

**Past Surgical History**

Yes No

Major operation

if so specify...

Minor operation

if so specify...


**Family History**

- Heart disease
- High blood pressure
- Diabetes Mellitus
- Asthma
- Tuberculosis
- Epilepsy
- Stroke
- Hepatitis B Carrier
- Hepatitis C Carrier
- Mental illness
- Blood disease
- Cancer
- Others

	Father	Mother	Uncle	Aunt	Brother	Sister	Daughter	Son
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B Carrier	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis C Carrier	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Others

**Drug History**

Drug allergy

Yes	No	Name of drugs	Oral	IV	How severe is the allergy?
<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	

Drugs currently taken

NIL

Singature



Date: 25/02/2025

**Physical Examination**

General appearance

Height	170 cm/		ft		inch	BMI	20.24	(kg / m <sup>2</sup> )	Underweight < 18.5	<input type="checkbox"/>
Weight	58.5 kg/		lb				Target 18.5 - 25		<input checked="" type="checkbox"/>	Overweight 25 - 30
									Obesity 30 - 40	<input type="checkbox"/>
									Extreme/ morbid obesity > 40	<input type="checkbox"/>

Eyes

Vision	Uncorrected	<input checked="" type="checkbox"/>	Corrected	<input type="checkbox"/>	Distant	L: <input type="checkbox"/> N	R: <input type="checkbox"/> N	Near	L: <input type="checkbox"/> N	R: <input type="checkbox"/> N	Colour vision	N	<input checked="" type="checkbox"/>	A	<input type="checkbox"/>
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Cardiovascular System Examination

N  A

Blood Pressure	134/72	mmHg	Heart Sounds	I+II+0
Pulse Rate / HR	80	/min		
	<input checked="" type="checkbox"/> Regular	<input type="checkbox"/> Irregular		

Respiratory System Examination

N      A

Abdomen Examination

N      A

<p>Respiratory rate    <input type="text" value="14"/> /min</p> <p>VBS                    <input type="text" value="+"/></p> <p>Additional sounds    <input type="text" value="-"/></p>	<p>Liver                <input type="checkbox"/> Palpable            <input checked="" type="checkbox"/> Not palpable</p> <p>Spleen              <input type="checkbox"/> Palpable            <input checked="" type="checkbox"/> Not palpable</p> <p>Kidney              <input type="checkbox"/> Ballotable          <input checked="" type="checkbox"/> Not ballotable</p> <p>Bowel sounds        <input type="text" value="+"/></p>
---	---

Nervous System Examination

N      A

Cognitive Function	<input checked="" type="checkbox"/>	Normal	<input type="checkbox"/>	Abnormal
Motor Power	<input checked="" type="checkbox"/>	Normal	<input type="checkbox"/>	Abnormal
Sensation	<input checked="" type="checkbox"/>	Normal	<input type="checkbox"/>	Abnormal
Gait	<input checked="" type="checkbox"/>	Normal	<input type="checkbox"/>	Abnormal
Neurological deficit	<input type="checkbox"/>	Present	<input checked="" type="checkbox"/>	Absent
Reflexes	<input checked="" type="checkbox"/>	Normal	<input type="checkbox"/>	Abnormal

Ear

Hearing		N	A
Left	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Right	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

N = Normal

A = Abnormal

ND = Not Done

		N	A	
General appearance	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Eyes	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Ear/Nose/Throat/Teeth	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Central Nervous System	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Thyroid	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Cardiovascular System	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Respiratory System	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Abdomen	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Spine	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Limbs	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

Others

Examined by	
Signature	
Name of MO	DR. Aye Hsu Swe
Date	25/02/2025

		N	A	ND	Report
CXR Finding	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	No abnormality detected.
USG	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	

		N	A	ND	Finding
ECG(EKG)	-Rest	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
	-Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
	-Holler	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	

If so specify

N A ND

CT Scan    If so specify...

Report

Echo cardiogram    If so specify...

**Laboratory Finding**

CP - Hb%	14.0 g/dl	Monocytes	
MCV	84.2 fL	Lymphocytes	
HCT	41.9 %	Basophils	
Neutrophils		Platelets	246 10 <sup>3</sup> / uL
Eosinophils		Total WBC	7.79 10 <sup>3</sup> / uL
Blood Film		RBC	4.98 10 <sup>6</sup> / uL

Test	Result	Ref. Value
<b>Lipid Profile</b>		
Cholesterol (Total)	3.92	< 5.2
	151	< 200
HDL Cholesterol	1.27	>= 1.6
	49	>= 62
LDL Cholesterol ( Direct )	2.61	< 3.3
	101	< 127
Triglycerides	0.56	< 1.7
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T.Chol/HDL Ratio	3.09	< 5
Uric Acid	231	202 - 417
Glucose	4.27	3.0 - 6.0 (Fasting) 4.0 - 7.8 (Non-Fasting)
SGOT (AST)	23	< 50 (Male)
SGPT (ALT)	27	< 50 (Male)
Alkaline Phosphatase	57	40 - 130 (Male)
Urea	3.0	2.8 - 8.1
Creatinine	84	59 - 104 (Male)
eGFR (CKD-EPI) (application to age >=18 yrs)	115	>=60

**Urine Examination**

**PHYSICAL & CHEMICAL EXAMINATION**

Colour		
Reaction		
Albumin		
Sugar		
Ketone Bodies		
Urobilinogen		
Bilirubin		
Blood		

Test	Result	Ref. Value
Specific gravity		
pH		
Nitrate		
Leucocytes		
<b>MICROSCOPIC EXAMINATION</b>		
RBC		
Pus cells		
Epithelial cells		
Crystals		
Casts		
Others		

Annual onshore check up  
 Medical History - Unremarkable.  
 Physical Examination - Unremarkable.  
 Chest X-ray - No abnormal finding  
 Laboratory findings - Within normal.  
 Audiometry - Normal findings

Comment

Fit  UnFit  for the proposed post.  
 Normal  Abnormal

DR. Aye Hsu Swe

Name of Doctor



Signature

**Dr. Aye Hsu Swe**  
**SAMA - 30643**

Stamp

Approved by

Name of Doctor

Signature

Stamp

The above recommendations are based solely on history you have provided, physical examination, imaging studies & laboratory tests at the time of screening. This general health screening might help you for your current health status and early detection of diseases, but cannot guarantee for your future health. Please consider our advice based on the findings of your results to achieve the best of your health.

Thank you for always choosing us, Asia Royal Hospital.