

# 1502

39

## 1.1 Appendix 32: EX1 Form (Initial Examination Report)

## INITIAL EXAMINATION REPORT (MEDICAL - CONFIDENTIAL)

 <b>Petroleum Development Oman MEDICAL DEPARTMENT</b> PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS		Surname Forenames <i>POOIAN SHABIMON</i> Address Home telephone number Employment No # <i>1502</i>																																																																																																																												
Place of examination	Date <i>28/03/2019</i>	Employment No # <i>1502</i>																																																																																																																												
If a dependant enter employee's name here: Surname: _____ Forenames: _____ Birth date: <i>31/05/1968</i> Nationality: <i>Indian</i> Country of birth: _____ Religion: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced Relationship to employee <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: <i>Help</i>																																																																																																																													
Name and address of family doctor (1) (2)		List your last 3 jobs (1) (2)																																																																																																																												
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? <i>no</i>		Average daily alcohol consumption <i>no</i>																																																																																																																												
Have you ever taken elicited drugs? <input checked="" type="checkbox"/> PDO test all new/potential employees for elicited/recreational drugs																																																																																																																														
FAMILY HISTORY: Diabetes <input checked="" type="checkbox"/> Tuberculosis <input checked="" type="checkbox"/> Epilepsy <input checked="" type="checkbox"/> Asthma <input checked="" type="checkbox"/> Eczema <input checked="" type="checkbox"/> Heart disease <input checked="" type="checkbox"/> High blood pressure <input checked="" type="checkbox"/> Stroke <input checked="" type="checkbox"/> Blood Disease <input checked="" type="checkbox"/> Cancer <input type="checkbox"/>																																																																																																																														
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: <i>29/3/19</i>	Signature of Applicant: <i>Shabimon</i>																																																																																																																													

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												
<input checked="" type="checkbox"/>	1. Eyes & Pupils												
<input checked="" type="checkbox"/>	2. E.N.T.												
<input checked="" type="checkbox"/>	3. Teeth & Mouth												
<input checked="" type="checkbox"/>	4. Lungs & Chest												
<input checked="" type="checkbox"/>	5. Cardiovascular System												
<input checked="" type="checkbox"/>	6. Abdo. Viscera												
<input checked="" type="checkbox"/>	7. Hernial Orifices												
<input checked="" type="checkbox"/>	8. Anus & Rectum												
<input checked="" type="checkbox"/>	9. Genito-urinary												
<input checked="" type="checkbox"/>	10. Extremities												
<input checked="" type="checkbox"/>	11. Musculo-skeletal												
<input checked="" type="checkbox"/>	12. Skin & Varicose Vns.												
<input checked="" type="checkbox"/>	13. C.N.S.												
HEIGHT cm	WEIGHT kg	BM I	B.P. —	PULSE /mins.	HEARING L R	VISION DISTANT R L				NEAR R L		Colour Vision	Blood Group
170cm	105	36.33	140/ 108	76	R	Uncorrected	6/6	6/6	NB	NB	(N)		
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS				N	A						
	1. Urinalysis							7. Audiogram					
	2. Hb, Blood count, ESR							8. Lung Function					
	3. LFT, RFT, RBS							9. Chest X-Ray					
	4. Drug Screen							10. ECG					
	5. Lipids (40 years +)							11. CVS risk for 40 yrs. & above					
	6. Sickle Cell test							12. HIV, Hepatitis screening					

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

Fracture neck of femur Risk score : 16% Known HTN

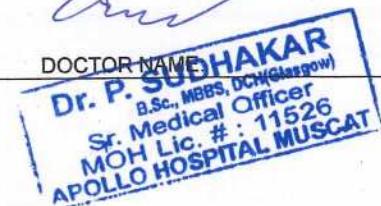
ASSESSMENT:

- FIT ALL AREAS
- FIT WITH SPECIFIC RESTRICTION
- TEMPORARY UNFIT
- AWAITING SPECIALIST ASSESSMENT

Dyslipidemia,  
Adhesive modification,  
Physician consultation

REVIEW/CONSULTATION

DATE: 02/04/19



SIGNATURE: