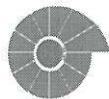




Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

Petroleum Development Oman
MEDICAL DEPARTMENTPLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALSPlace of examination **NMC AL-HAIL** Date **02/09/2013** Home telephone number

If a dependant enter employee's name here:

Surname: **SUKUMARAN** Forenames: **SUNDARESAN**Birth date: **27/05/1964** 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	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: _____

Name and address of family doctor List your last 3 jobs

(1)

(2)

Are you a Registered Disabled Person? (UK only) Do you belong to any Medical Insurance Scheme?

DO YOU HAVE OR HAVE YOU HAD:- (Tick "Yes" or "No" column or put a (?) if uncertain exclude minor ailments.)

	Y	N		Y	N		Y	N
1. Sinus trouble	<input checked="" type="checkbox"/>	<input type="checkbox"/>	21. Cancer	<input checked="" type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER BEEN:-		
2. Neck swelling/glands	<input checked="" type="checkbox"/>	<input type="checkbox"/>	22. Heart Disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>	40. Rejected for emplyment or insurance for medica reasons	<input checked="" type="checkbox"/>	
3. Difficulty in vision	<input checked="" type="checkbox"/>	<input type="checkbox"/>	23. Rheumatic fever	<input checked="" type="checkbox"/>	<input type="checkbox"/>	41. Awarded benefits for industria injury/illness	<input checked="" type="checkbox"/>	
4. Any ear discharge	<input checked="" type="checkbox"/>	<input type="checkbox"/>	24. Abnormal heartbeat	<input checked="" type="checkbox"/>	<input type="checkbox"/>	42. Treated for a mental condition e.g. depression	<input checked="" type="checkbox"/>	
5. Asthma/bronchitis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	25. High blood pressure	<input checked="" type="checkbox"/>	<input type="checkbox"/>	43. Treated for problem drinking or drug abuse	<input checked="" type="checkbox"/>	
6. Hayfever /other significant allergy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	26. Stroke	<input checked="" type="checkbox"/>	<input type="checkbox"/>	44. Exposed to toxic substance or noise	<input checked="" type="checkbox"/>	
7. Any skin trouble	<input checked="" type="checkbox"/>	<input type="checkbox"/>	27. Serious chest pain	<input checked="" type="checkbox"/>	<input type="checkbox"/>	FOR WOMEN ONLY		
8. Tuberculosis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	28. Any blood disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Have you ever had:-		
9. Shortness of breath	<input checked="" type="checkbox"/>	<input type="checkbox"/>	29. Kidney disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>	45. An abnormal smear	<input type="checkbox"/>	
10. Coughed/vomited blood	<input checked="" type="checkbox"/>	<input type="checkbox"/>	30. Blood in urine	<input checked="" type="checkbox"/>	<input type="checkbox"/>	46. Any gynaecological treatment	<input type="checkbox"/>	
11. Severe abdominal pain	<input checked="" type="checkbox"/>	<input type="checkbox"/>	31. Diabetes	<input checked="" type="checkbox"/>	<input type="checkbox"/>	47. Are you pregnant?	<input type="checkbox"/>	
12. Stomach ulcer	<input checked="" type="checkbox"/>	<input type="checkbox"/>	32. Headaches/migraine	<input checked="" type="checkbox"/>	<input type="checkbox"/>	48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE	<input type="checkbox"/>	
13. Recurrent indigestion	<input checked="" type="checkbox"/>	<input type="checkbox"/>	33. Dizziness/fainting	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
14. Jaundice or hepatitis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	34. Epilepsy	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
15. Gall Bladder disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>	35. Joints/spinal trouble	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
16. Marked change in bowel habits	<input checked="" type="checkbox"/>	<input type="checkbox"/>	36. Surgical operation	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
17. Blood in stools (motions)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	37. Serious accident/fracture	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
18. Marked change in weight	<input checked="" type="checkbox"/>	<input type="checkbox"/>	38. Tropical disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
19. Varicose veins	<input checked="" type="checkbox"/>	<input type="checkbox"/>	39. Fear of heights	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
20. Lump in breast/armpit	<input checked="" type="checkbox"/>	<input type="checkbox"/>						

How much tobacco each day? Average daily alcohol consumption **Twice / Month**Have you ever taken elicited drugs? 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 checked="" type="checkbox"/>
	C.R. No: 1668137				

PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT:-

I declare 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: **25-09-2013**Signature of Applicant: **Sukumaran**



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	BSP vision is 6/6, Presbyopia is cured using glasses.									
<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	Herniorraphy scar (inguinal).									
<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	BMI	B.P. 130/80	PULSE 62/mins.	HEARING L (N) R (N)	VISION Uncorrected Corrected	DISTANT R L	NEAR R L	Colour Vision	Blood Group	
167	73	26.1					6/6	6/6	Normal		

N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS			N	A			
<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>		7. Audiogram		
<input checked="" type="checkbox"/>		1. Urinalysis			<input checked="" type="checkbox"/>		8. Lung Function		
<input checked="" type="checkbox"/>		2. Hb, Bloodcount, ESR					9. Chest X-Ray		
<input checked="" type="checkbox"/>		3. LFT, RFT, RBS					10. ECG		
<input checked="" type="checkbox"/>		4. Drug Screen					11. CVS risk for 40 yrs. & above 21.5%		
<input checked="" type="checkbox"/>		5. Lipids (40 years +)					12. HIV, Hepatitis screening		
<input checked="" type="checkbox"/>		6. Sickle Cell test							

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



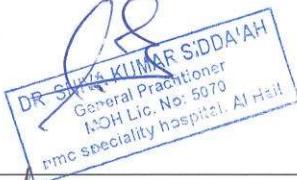
ASSESSMENT:

 FIT ALL AREAS FIT WITH RESTRICTION TEMPORARY UNFIT UNFIT

Date:

Name (Block Capitals): Dr. / Nurse

Signature:



REVIEW/CONSULTATION

Cardiology fitness. 8/ TMT required.

Date:

Name (Block Capitals): Dr. / Nurse

Signature:

Page 8C	DR. ASWATHY RAVI Specification General Practitioner MOH Lic. No: 20556	
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