

#1774

(2)

## 1.1 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  
**Haima**Date **28/3/19**

Surname <b>AMRIK SINGH</b>	
Forenames	
Address	
Home telephone number	
Employment No # <b>1774</b>	

If a dependant enter employee's name here:

Surname:

Forenames:

Birth date: **04/07/1979**Nationality: **Indian**Country of birth: **5-06-1979**

Religion:

 Male  Female Married  Single Separated /Divorced Wife  Son  DaughterNumber of  
children: **02**

Reason for examination

Pre-Employment

 Job:

Pre-Overseas

 Area: **Driver**

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 employment or insurance for medical 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 industrial 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:-	<b>NA</b>	
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		
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		
11. Severe abdominal pain	<input checked="" type="checkbox"/>	<input type="checkbox"/>	31. Diabetes	<input checked="" type="checkbox"/>	<input type="checkbox"/>	47. Are you pregnant?		
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		
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?

**NO**

Average daily alcohol consumption

**NO**Have you ever taken elicited drugs?  PDO test all new/potential employees for elicited/recreational drugsFAMILY HISTORY: Diabetes  Tuberculosis  Epilepsy  Asthma  Eczema   
Heart disease  High blood pressure  Stroke  Blood Disease  Cancer 

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: **28/3/19**Signature of Applicant: **AS**

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 164 cm		WEIGHT kg 82	BM 1 30	B.P. 130/90	PULSE /mins. 76	HEARING L R Uncorrected Corrected	VISION DISTANT R L 6/6				NEAR R L 6/6 N/6 N/6	Colour Vision N	Blood Group
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.)													
Framingham Risk Score 3.0 %													
ASSESSMENT:													
<input checked="" type="checkbox"/> FIT ALL AREAS <input type="checkbox"/> FIT WITH SPECIFIC RESTRICTION <input type="checkbox"/> TEMPORARY UNFIT <input type="checkbox"/> AWAITING SPECIALIST ASSESSMENT													
REVIEW/CONSULTATION													
DATE: 02/04/19 <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; padding: 5px; margin-right: 10px;">           DOCTOR NAME: Dr. P. SUDHAKAR            B.Sc., MBBS, DCH (Lampore)            Sr. Medical Officer            MOH Lic. # : 11528            APOLLO HOSPITAL MUSCAT         </div> <div style="margin-right: 10px;">  </div> <div>           SIGNATURE: _____         </div> </div>													