

6

1.1 Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)



Petroleum Development Oman
MEDICAL DEPARTMENT

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Place of examination <i>Adam</i>	Date <i>29/3/19</i>	Surname <i>RAMPAL Harbans Lal</i>	
		Forenames	
		Address	
		Home telephone number	
		Employment No # <i>1775</i>	

If a dependant enter employee's name here:

Surname: <i>90121982</i>	Forenames:		
Birth date: <i>90121982</i>	Nationality: <i>Indian</i>	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 checked="" type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	Relationship to employee
			Number of children: <i>2</i>

Reason for examination	Pre-Employment <input type="checkbox"/>	Job: <i>Driver</i>
	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) <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.)

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

How much tobacco each day? <i>no</i>	Average daily alcohol consumption <i>no</i>
--------------------------------------	---

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"/>

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>Ram Paul</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											
✓	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	BM I	B.P. 150 90	PULSE /mins. 78	HEARING L R	VISION DISTANT R L R L Uncorrected Corrected 6/6 6/6 6/6 6/6				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.)

Frailty assessment Risk score: 2 %

ASSESSMENT:

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

Dyslipidaemia
Ad life style modifications
TO Rx for lipid profile in 3 months

REVIEW/CONSULTATION

DATE: 02/04/19


DOCTOR NAME: Dr. P. SUDHAKAR (MBBS, DCH (Glasgow))
Sr. Medical Officer
MOH Lic. # 11526
APOLLO HOSPITAL MUSCAT

SIGNATURE: