

#1553

(25)

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		Date 28.03.2019		Surname MD SUJAN MIA	
				Forenames Address	
				Home telephone number	
				Employment No # 1553	
If a dependant enter employee's name here:					
Surname: 9171985		Forenames:			
Birth date: 9171985		Nationality:		Country of birth:	
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		<input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced		<input type="checkbox"/> Wife <input checked="" type="checkbox"/> Son <input type="checkbox"/> Daughter	
Reason for examination		Pre-Employment <input type="checkbox"/>		Job: HELPER	
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	
1. Sinus trouble		<input checked="" type="checkbox"/> 21. Cancer		<input checked="" type="checkbox"/> HAVE YOU EVER BEEN:- 40. Rejected for employment or insurance for medical reasons	
2. Neck swelling/glands		<input checked="" type="checkbox"/> 22. Heart Disease		<input checked="" type="checkbox"/> 41. Awarded benefits for industrial injury/illness	
3. Difficulty in vision		<input checked="" type="checkbox"/> 23. Rheumatic fever		<input checked="" type="checkbox"/> 42. Treated for a mental condition, e.g. depression	
4. Any ear discharge		<input checked="" type="checkbox"/> 24. Abnormal heartbeat		<input checked="" type="checkbox"/> 43. Treated for problem drinking or drug abuse	
5. Asthma/bronchitis		<input checked="" type="checkbox"/> 25. High blood pressure		<input checked="" type="checkbox"/> 44. Exposed to toxic substance or noise	
6. Hayfever /other significant allergy		<input checked="" type="checkbox"/> 26. Stroke		<input checked="" type="checkbox"/> FOR WOMEN ONLY Have you ever had:- 45. An abnormal smear	
7. Any skin trouble		<input checked="" type="checkbox"/> 27. Serious chest pain		<input checked="" type="checkbox"/> 46. Any gynaecological treatment	
8. Tuberculosis		<input checked="" type="checkbox"/> 28. Any blood disease		<input checked="" type="checkbox"/> 47. Are you pregnant?	
9. Shortness of breath		<input checked="" type="checkbox"/> 29. Kidney disease		<input checked="" type="checkbox"/> 48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE	
10. Coughed/vomited blood		<input checked="" type="checkbox"/> 30. Blood in urine			
11. Severe abdominal pain		<input checked="" type="checkbox"/> 31. Diabetes			
12. Stomach ulcer		<input checked="" type="checkbox"/> 32. Headaches/migraine			
13. Recurrent indigestion		<input checked="" type="checkbox"/> 33. Dizziness/fainting			
14. Jaundice or hepatitis		<input checked="" type="checkbox"/> 34. Epilepsy			
15. Gall Bladder disease		<input checked="" type="checkbox"/> 35. Joints/spinal trouble			
16. Marked change in bowel habits		<input checked="" type="checkbox"/> 36. Surgical operation			
17. Blood in stools (motions)		<input checked="" type="checkbox"/> 37. Serious accident/fracture			
18. Marked change in weight		<input checked="" type="checkbox"/> 38. Tropical disease			
19. Varicose veins		<input checked="" type="checkbox"/> 39. Fear of heights			
20. Lump in breast/armpit					
How much tobacco each day? MD			Average daily alcohol consumption NO		
Have you ever taken elicited drugs? NO PDO test all new/potential employees for elicited/recreational drugs					
FAMILY HISTORY: Diabetes (Y) Tuberculosis (Y) Epilepsy (Y) Asthma (Y) Eczema (Y) Heart disease (Y) High blood pressure (Y) Stroke (Y) Blood Disease (Y) 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: Sujan			

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. mm Hg	PULSE 80/mins.	HEARING L R	VISION				Colour Vision	Blood Group
						DISTANT R L	NEAR R L	Uncorrected	Corrected		
165	60	22.5	120/80			6/6	6/6	N/6	N/6	(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.)

Frannum Score :- < 1%

ASSESSMENT:

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

Dyspnoea
Ad lib. mouth breath
To R/R lip proptyle
3m/s

REVIEW/CONSULTATION

DATE: 02/04/19

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

SIGNATURE: