

# 1785

(17)

## 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 CAPITALS

Place of examination Adam.		Date 29/3/19	Surname Shibir Varghese.																																																																																				
			Forenames																																																																																				
			Address																																																																																				
			Home telephone number																																																																																				
			Employment No # 1785																																																																																				
If a dependant enter employee's name here: Surname: 3-11-1994		Forenames:																																																																																					
Birth date: 3-11-1994		Nationality: India	Country of birth:	Religion:																																																																																			
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Married <input checked="" type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced	Relationship to employee <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter																																																																																				
Reason for examination		Pre-Employment <input type="checkbox"/>	Job: Store keeper																																																																																				
		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.)																																																																																							
<table border="1"> <tr> <th>Y</th> <th>N</th> </tr> <tr> <td colspan="2">1. Sinus trouble</td> </tr> <tr> <td colspan="2">2. Neck swelling/glands</td> </tr> <tr> <td colspan="2">3. Difficulty in vision</td> </tr> <tr> <td colspan="2">4. Any ear discharge</td> </tr> <tr> <td colspan="2">5. Asthma/bronchitis</td> </tr> <tr> <td colspan="2">6. Hayfever /other significant allergy</td> </tr> <tr> <td colspan="2">7. Any skin trouble</td> </tr> <tr> <td colspan="2">8. Tuberculosis</td> </tr> <tr> <td colspan="2">9. Shortness of breath</td> </tr> <tr> <td colspan="2">10. Coughed/vomited blood</td> </tr> <tr> <td colspan="2">11. Severe abdominal pain</td> </tr> <tr> <td colspan="2">12. Stomach ulcer</td> </tr> <tr> <td colspan="2">13. Recurrent indigestion</td> </tr> <tr> <td colspan="2">14. Jaundice or hepatitis</td> </tr> <tr> <td colspan="2">15. Gall Bladder disease</td> </tr> <tr> <td colspan="2">16. Marked change in bowel habits</td> </tr> <tr> <td colspan="2">17. Blood in stools (motions)</td> </tr> <tr> <td colspan="2">18. Marked change in weight</td> </tr> <tr> <td colspan="2">19. Varicose veins</td> </tr> <tr> <td colspan="2">20. Lump in breast/armpit</td> </tr> </table>		Y	N	1. Sinus trouble		2. Neck swelling/glands		3. Difficulty in vision		4. Any ear discharge		5. Asthma/bronchitis		6. Hayfever /other significant allergy		7. Any skin trouble		8. Tuberculosis		9. Shortness of breath		10. Coughed/vomited blood		11. Severe abdominal pain		12. Stomach ulcer		13. Recurrent indigestion		14. Jaundice or hepatitis		15. Gall Bladder disease		16. Marked change in bowel habits		17. Blood in stools (motions)		18. Marked change in weight		19. Varicose veins		20. Lump in breast/armpit		<table border="1"> <tr> <th>Y</th> <th>N</th> </tr> <tr> <td colspan="2">21. Cancer</td> </tr> <tr> <td colspan="2">22. Heart Disease</td> </tr> <tr> <td colspan="2">23. Rheumatic fever</td> </tr> <tr> <td colspan="2">24. Abnormal heartbeat</td> </tr> <tr> <td colspan="2">25. High blood pressure</td> </tr> <tr> <td colspan="2">26. Stroke</td> </tr> <tr> <td colspan="2">27. Serious chest pain</td> </tr> <tr> <td colspan="2">28. Any blood disease</td> </tr> <tr> <td colspan="2">29. Kidney disease</td> </tr> <tr> <td colspan="2">30. Blood in urine</td> </tr> <tr> <td colspan="2">31. Diabetes</td> </tr> <tr> <td colspan="2">32. Headaches/migraine</td> </tr> <tr> <td colspan="2">33. Dizziness/fainting</td> </tr> <tr> <td colspan="2">34. Epilepsy</td> </tr> <tr> <td colspan="2">35. Joints/spinal trouble</td> </tr> <tr> <td colspan="2">36. Surgical operation</td> </tr> <tr> <td colspan="2">37. Serious accident/fracture</td> </tr> <tr> <td colspan="2">38. Tropical disease</td> </tr> <tr> <td colspan="2">39. Fear of heights</td> </tr> </table>		Y	N	21. Cancer		22. Heart Disease		23. Rheumatic fever		24. Abnormal heartbeat		25. High blood pressure		26. Stroke		27. Serious chest pain		28. Any blood disease		29. Kidney disease		30. Blood in urine		31. Diabetes		32. Headaches/migraine		33. Dizziness/fainting		34. Epilepsy		35. Joints/spinal trouble		36. Surgical operation		37. Serious accident/fracture		38. Tropical disease		39. Fear of heights		HAVE YOU EVER BEEN:- 40. Rejected for employment or insurance for medical reasons 41. Awarded benefits for industrial injury/illness 42. Treated for a mental condition, e.g. depression 43. Treated for problem drinking or drug abuse 44. Exposed to toxic substance or noise <b>FOR WOMEN ONLY</b> Have you ever had:- 45. An abnormal smear 46. Any gynaecological treatment 47. Are you pregnant? 48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE	
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How much tobacco each day? NO		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 (P)	Tuberculosis (P)	Epilepsy (P)	Asthma (P)	Eczema (P)																																																																																	
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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: 29/3/19	Signature of Applicant:																																																																																						

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. 120/ 80	PULSE /mins. 76	HEARING L R	VISION DISTANT Uncorrected Corrected		R 6/6 6/6	L 6/6 6/6	NEAR R 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.)

Assessment:	
<input checked="" type="checkbox"/> FIT ALL AREAS	Score : 0 %
<input type="checkbox"/> FIT WITH SPECIFIC RESTRICTION	2 G1b1c1 syndrome
<input type="checkbox"/> TEMPORARY UNFIT	
<input type="checkbox"/> AWAITING SPECIALIST ASSESSMENT	
REVIEW/CONSULTATION	
DATE: 02/04/19	
DOCTOR NAME: Dr. P. SEDHAKAR B.Sc., MBBS, DCH (Glasgow) Sr. Medical Officer MOH Lic. # : 11526 APOLLO HOSPITAL MUSCAT	
SIGNATURE:	