

1808

(22)

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 <i>Adam</i>	Date <i>29/3/19</i>	Surname <i>Mohammed Asim</i>
		Forenames
		Address
		Home telephone number
		Employment No # <i>1808</i>

If a dependant enter employee's name here:

Surname: <i>15/9/83</i>	Forenames: <i>Pakistani</i>		
Birth date: <i>15/9/83</i>	Nationality: <i>Pakistani</i>	Country of birth:	Religion:
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input 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>Mechanic</i>
	Pre-Overseas	<input type="checkbox"/> Area:

Name and address of family doctor	List your last 3 jobs (1) (2)
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Are you a Registered Disabled Person? (UK only)	<input type="checkbox"/>	Do you belong to any Medical Insurance Scheme?	<input type="checkbox"/>
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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"/>		HAVE YOU EVER BEEN:-		
2. Neck swelling/glands	<input checked="" type="checkbox"/>		22. Heart Disease	<input checked="" type="checkbox"/>		40. Rejected for employment or insurance for medical reasons		
3. Difficulty in vision	<input checked="" type="checkbox"/>		23. Rheumatic fever	<input checked="" type="checkbox"/>		41. Awarded benefits for industrial injury/illness		
4. Any ear discharge	<input checked="" type="checkbox"/>		24. Abnormal heartbeat	<input checked="" type="checkbox"/>		42. Treated for a mental condition, e.g. depression		
5. Asthma/bronchitis	<input checked="" type="checkbox"/>		25. High blood pressure	<input checked="" type="checkbox"/>		43. Treated for problem drinking or drug abuse		
6. Hayfever /other significant allergy	<input checked="" type="checkbox"/>		26. Stroke	<input checked="" type="checkbox"/>		44. Exposed to toxic substance or noise		
7. Any skin trouble	<input checked="" type="checkbox"/>		27. Serious chest pain	<input checked="" type="checkbox"/>		FOR WOMEN ONLY		
8. Tuberculosis	<input checked="" type="checkbox"/>		28. Any blood disease	<input checked="" type="checkbox"/>		Have you ever had:-	<i>NA</i>	
9. Shortness of breath	<input checked="" type="checkbox"/>		29. Kidney disease	<input checked="" type="checkbox"/>		45. An abnormal smear		
10. Coughed/vomited blood	<input checked="" type="checkbox"/>		30. Blood in urine	<input checked="" type="checkbox"/>		46. Any gynaecological treatment		
11. Severe abdominal pain	<input checked="" type="checkbox"/>		31. Diabetes	<input checked="" type="checkbox"/>		47. Are you pregnant?		
12. Stomach ulcer	<input checked="" type="checkbox"/>		32. Headaches/migraine	<input checked="" type="checkbox"/>		48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE		
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? *0.0* Average daily alcohol consumption *0.0*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>PLA</i>
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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		WEIGHT kg	BM I	B.P. 140 90	PULSE /mins. 76	HEARING L R	VISION DISTANT R L R L Uncorrected 6/6 6/6 6/6 6/6 Corrected				Colour Vision N	Blood Group
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS				N	A					
								7. Audiogram				
								8. Lung Function				
								9. Chest X-Ray				
								10. ECG				
								11. CVS risk for 40 yrs. & above				
								12. HIV, Hepatitis screening				

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

Framingham Risk Score : 12 %	
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	
<p>DATE: 02/04/19</p> <p>DOCTOR NAME: Dr. P. MANDHAKAR B.Sc., M.B.B.S. DCH(Glasgow) Sr. Medical Officer MOH Lic. # : 11526 APOLLO HOSPITAL MUSCAT</p>	
SIGNATURE:	

Dyslipidemia
Adhesive stylo-mastoid flm.
To & fm. lip. post op. afli
3 mm Hg