

#1817

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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 | Surname | | Forenames | | Address | | Home telephone number | | Employment No # | |
| | | 28/3/19 | Ligin Lal | | | | | | | | 1817 | |
| If a dependant enter employee's name here: | | | | | | | | | | | | |
| Surname: | | | | | | Forenames: | | | | | | |
| Birth date: 22-5-97 | | | Nationality: Indian | | | 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 type="checkbox"/> Relationship to employee Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter | | | | Number of children: | | | | |
| Reason for examination | | Pre-Employment <input type="checkbox"/> Pre-Overseas <input type="checkbox"/> | | Job: | | Helper | | | | | | |
| 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 | | | | 21. Cancer | | | | HAVE YOU EVER BEEN:- | | | | |
| 2. Neck swelling/glands | | | | 22. Heart Disease | | | | 40. Rejected for employment or insurance for medical reasons | | | | |
| 3. Difficulty in vision | | | | 23. Rheumatic fever | | | | 41. Awarded benefits for industrial injury/illness | | | | |
| 4. Any ear discharge | | | | 24. Abnormal heartbeat | | | | 42. Treated for a mental condition, e.g. depression | | | | |
| 5. Asthma/bronchitis | | | | 25. High blood pressure | | | | 43. Treated for problem drinking or drug abuse | | | | |
| 6. Hayfever /other significant allergy | | | | 26. Stroke | | | | 44. Exposed to toxic substance or noise | | | | |
| 7. Any skin trouble | | | | 27. Serious chest pain | | | | FOR WOMEN ONLY | | | | |
| 8. Tuberculosis | | | | 28. Any blood disease | | | | Have you ever had:- | | | | |
| 9. Shortness of breath | | | | 29. Kidney disease | | | | 45. An abnormal smear | | | | |
| 10. Coughed/vomited blood | | | | 30. Blood in urine | | | | 46. Any gynaecological treatment | | | | |
| 11. Severe abdominal pain | | | | 31. Diabetes | | | | 47. Are you pregnant? | | | | |
| 12. Stomach ulcer | | | | 32. Headaches/migraine | | | | 48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE | | | | |
| 13. Recurrent indigestion | | | | 33. Dizziness/fainting | | | | | | | | |
| 14. Jaundice or hepatitis | | | | 34. Epilepsy | | | | | | | | |
| 15. Gall Bladder disease | | | | 35. Joints/spinal trouble | | | | | | | | |
| 16. Marked change in bowel habits | | | | 36. Surgical operation | | | | | | | | |
| 17. Blood in stools (motions) | | | | 37. Serious accident/fracture | | | | | | | | |
| 18. Marked change in weight | | | | 38. Tropical disease | | | | | | | | |
| 19. Varicose veins | | | | 39. Fear of heights | | | | | | | | |
| 20. Lump in breast/arm/pit | | | | | | | | | | | | |
| How much tobacco each day? no | | | | Average daily alcohol consumption no | | | | | | | | |
| Have you ever taken elicited drugs? (X) PDO test all new/potential employees for elicited/recreational drugs | | | | | | | | | | | | |
| FAMILY HISTORY: Diabetes (X) Tuberculosis (X) Epilepsy (X) Asthma (X) Eczema (X) Heart disease (X) High blood pressure (X) Stroke (X) Blood Disease (X) Cancer (X) | | | | | | | | | | | | |
| 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: [Signature] | | | | | | | | |

N = Normal A = Abnormal (please describe)

| 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. |

| 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. Sickie Cell test | | | | 12. HIV, Hepatitis screening |

Farmviktam Risk Score $< 1\%$

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

• Gilbert syndrome

DATE: 02/04/11

DOCTOR NAME

SIGNATURE:

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