

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS



Petroleum Development Oman
MEDICAL DEPARTMENT

INITIAL EXAMINATION REPORT

Place of examination BADR AL SAMAA HOSPITAL AL KHOUD BRANCH		Date:- 25 / 11 / 2019		Surname KHALAF NASSER AL MUJARFI	
				Forenames ZAID ALI	
				Address	
				Home Telephone Number 96993292	
If a dependant or partner enter employee's name here:- Surname: Forenames:					
Birth date 12 / 11 / 1994		Nationality OMANI		Country of birth OMAN	
Religion ISLAM					
<input checked="" type="checkbox"/> Male <input checked="" type="checkbox"/> Single <input type="checkbox"/> Widow (er)		Relationship to employee		Number of Children	
<input type="checkbox"/> Female <input type="checkbox"/> Married <input type="checkbox"/> Divorced/ Separated		<input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Fiancee			
Reason for examination <input type="checkbox"/> Pre-employment <input type="checkbox"/> Pre-overseas		Job:- Area:-			
Name and address of family doctor		List your last 3 jobs			
		(1)			
		(2)			
		(3)			
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		✓	22. Heart Disease		✓
2. Neck swelling/glands		✓	23. Rheumatic fever		✓
3. Difficulty in vision		✓	24. Abnormal heartbeat		✓
4. Any ear discharge		✓	25. High blood pressure		✓
5. Asthma/bronchitis		✓	26. Stroke		✓
6. Hayfever/other allergy		✓	27. Serious chest pain		✓
7. Any skin trouble		✓	28. Any blood disease		✓
8. Tuberculosis		✓	29. Kidney disease		✓
9. Shortness of breath		✓	30. Painful passage of urine		✓
10. Coughed/vomited blood		✓	31. Blood in urine		✓
11. Severe abdominal pain		✓	32. Diabetes		✓
12. Stomach ulcer		✓	33. Headaches/migraine		✓
13. Recurrent Indigestion		✓	34. Dizziness/fainting		✓
14. Jaundice or hepatitis		✓	35. Epilepsy		✓
15. Gall Bladder disease		✓	36. Joints/spinal trouble		✓
16. Marked change in bowel habits		✓	37. Surgical operation		✓
17. Blood in stools (motions)		✓	38. Serious accident/fracture		✓
18. Marked change in weight		✓	39. Tropical disease		✓
19. Varicose veins		✓	40. Fear of heights		✓
20. Lump in breast/armpit		✓	41. Rejected for employment or insurance for medical reasons		✓
21. Cancer		✓			
How much tobacco each day? <input checked="" type="checkbox"/>		Average daily alcohol consumption			
FAMILY HISTORY Diabetes <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Epilepsy <input type="checkbox"/> Asthma <input type="checkbox"/> Eczema <input type="checkbox"/>					
Heart disease <input type="checkbox"/> High blood pressure <input type="checkbox"/> Stroke <input type="checkbox"/> Cancer <input type="checkbox"/> Blood Disease <input type="checkbox"/>					
PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT:- I declare 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.					
Date: 25.11.2019		Signature of applicant:			



FOR COMPLETION BY EXAMINING DOCTOR OR SISTER
Further details of medical history and recreational activities

N = Normal A = Abnormal (please describe)		PHYSICAL EXAMINATION	
N	A		
✓		1. Eyes & Pupils	NORMAL
✓		2. E.N.T.	REPORTS ATTACHED
✓		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.	
✓		14. Breasts	

HEIGHT	WEIGHT	B.P.	PULSE	HEARING	VISION	DISTANT	NEAR	COLOUR	BLOOD
cm	kg			L 16.6		R L	R L	VISION	GROUP
181	70	120/80 mmHG	72/Mints	R 11.6	Uncorrected	6/6 6/6	N6 N6	PRESENT	
					Corrected				

N	A	LABORATORY AND SPECIAL INVESTIGATIONS		N	A
✓		1. Urinalysis		✓	6. Audiogram
✓		2. Hb Blood count ESR	N/A		7. Lung Function
✓		3. Serum Profile		✓	8. Chest X-Ray
		4. Stool	N/A		9. Drug Screen
✓		5. E.C.G.	N/A		10. CR Screen = Country Request (e.g. H.I.V.)

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

[Handwritten signature]

ASSESSMENT

☒ FIT ALL AREAS
 ☐ FIT HOME SERVICE ONLY
 ☐ UNFIT/UNSUITABLE
 ☐ MAY BE REASSESSED

25.11.2019

Date

Signature

DR NAVEEN NAZIRUDEEN

Name (Block Capitals)

Doctor/Sister

REVIEW/CONSULTATION

Date

Signature

Name (Block Capitals)

Doctor/Sister

