

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 | |
| 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 type="checkbox"/> Single <input type="checkbox"/> Widow (er) | | Relationship to employee <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Fiancee | | Number of Children |
| <input type="checkbox"/> Female <input type="checkbox"/> Married <input type="checkbox"/> Divorced/ Separated | | | | |
| 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.) | | | | |
| 1. Sinus trouble | Y <input checked="" type="checkbox"/> N <input type="checkbox"/> | 22. Heart Disease | Y <input checked="" type="checkbox"/> N <input type="checkbox"/> | 42. Awarded benefits for industrial injury/illness |
| 2. Neck swelling/glands | Y <input checked="" type="checkbox"/> N <input type="checkbox"/> | 23. Rheumatic fever | Y <input checked="" type="checkbox"/> N <input type="checkbox"/> | 43. Treated for a mental condition, eg depression |
| 3. Difficulty in vision | Y <input checked="" type="checkbox"/> N <input type="checkbox"/> | 24. Abnormal heartbeat | Y <input checked="" type="checkbox"/> N <input type="checkbox"/> | 44. Treated for problem drinking or drug abuse |
| 4. Any ear discharge | Y <input checked="" type="checkbox"/> N <input type="checkbox"/> | 25. High blood pressure | Y <input checked="" type="checkbox"/> N <input type="checkbox"/> | 45. Exposed to toxic substance or noise |
| 5. Asthma/bronchitis | Y <input checked="" type="checkbox"/> N <input type="checkbox"/> | 26. Stroke | Y <input checked="" type="checkbox"/> N <input type="checkbox"/> | |
| 6. Hayfever/other allergy | Y <input checked="" type="checkbox"/> N <input type="checkbox"/> | 27. Serious chest pain | Y <input checked="" type="checkbox"/> N <input type="checkbox"/> | |
| 7. Any skin trouble | Y <input checked="" type="checkbox"/> N <input type="checkbox"/> | 28. Any blood disease | Y <input checked="" type="checkbox"/> N <input type="checkbox"/> | |
| 8. Tuberculosis | Y <input checked="" type="checkbox"/> N <input type="checkbox"/> | 29. Kidney disease | Y <input checked="" type="checkbox"/> N <input type="checkbox"/> | |
| 9. Shortness of breath | Y <input checked="" type="checkbox"/> N <input type="checkbox"/> | 30. Painful passage of urine | Y <input checked="" type="checkbox"/> N <input type="checkbox"/> | FOR WOMEN ONLY |
| 10. Coughed/vomited blood | Y <input checked="" type="checkbox"/> N <input type="checkbox"/> | 31. Blood in urine | Y <input checked="" type="checkbox"/> N <input type="checkbox"/> | Have you ever had:- |
| 11. Severe abdominal pain | Y <input checked="" type="checkbox"/> N <input type="checkbox"/> | 32. Diabetes | Y <input checked="" type="checkbox"/> N <input type="checkbox"/> | |
| 12. Stomach ulcer | Y <input checked="" type="checkbox"/> N <input type="checkbox"/> | 33. Headaches/migraine | Y <input checked="" type="checkbox"/> N <input type="checkbox"/> | |
| 13. Recurrent Indigestion | Y <input checked="" type="checkbox"/> N <input type="checkbox"/> | 34. Dizziness/fainting | Y <input checked="" type="checkbox"/> N <input type="checkbox"/> | |
| 14. Jaundice or hepatitis | Y <input checked="" type="checkbox"/> N <input type="checkbox"/> | 35. Epilepsy | Y <input checked="" type="checkbox"/> N <input type="checkbox"/> | |
| 15. Gall Bladder disease | Y <input checked="" type="checkbox"/> N <input type="checkbox"/> | 36. Joints/spinal trouble | Y <input checked="" type="checkbox"/> N <input type="checkbox"/> | |
| 16. Marked change in bowel habits | Y <input checked="" type="checkbox"/> N <input type="checkbox"/> | 37. Surgical operation | Y <input checked="" type="checkbox"/> N <input type="checkbox"/> | |
| 17. Blood in stools (motions) | Y <input checked="" type="checkbox"/> N <input type="checkbox"/> | 38. Serious accident/fracture | Y <input checked="" type="checkbox"/> N <input type="checkbox"/> | |
| 18. Marked change in weight | Y <input checked="" type="checkbox"/> N <input type="checkbox"/> | 39. Tropical disease | Y <input checked="" type="checkbox"/> N <input type="checkbox"/> | |
| 19. Varicose veins | Y <input checked="" type="checkbox"/> N <input type="checkbox"/> | 40. Fear of heights | Y <input checked="" type="checkbox"/> N <input type="checkbox"/> | |
| 20. Lump in breast/armpit | Y <input checked="" type="checkbox"/> N <input type="checkbox"/> | HAVE YOU EVER BEEN:- | | |
| 21. Cancer | Y <input checked="" type="checkbox"/> N <input type="checkbox"/> | 41. Rejected for employment or insurance for medical reasons | | |
| 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

DR. ENILPA. A
D.O.M.S
Ophthalmologist
Moh. License No. 8975

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

ASSESSMENT

FIT ALL AREAS

FIT HOME SERVICE ONLY

Dr. NAVEEN NAZIRUDEEN
M.B.B.S, DNB (Gen. Medicine)
INTERNIST
M.O.H. License No. 8975

UNFIT/UNSUITABLE

MAY BE REASSESSED

25.11.2019

DR NAVEEN NAZIRUDEEN

Date Signature

Name (Block Capitals)

Doctor/Sister

REVIEW/CONSULTATION

Date

Signature

Name (Block Capitals)



Doctor/Sister