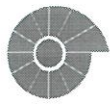


Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)



**Petrochem Development Oman
MEDICAL DEPARTMENT**

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Surname <u>Singh</u>		Forenames <u>Hardeep Singh</u>	
Address <u></u>			
Home telephone number <u></u>			
Place of examination <u>MNC - Har</u>		Date <u>16/01/2022</u>	
If a dependant enter employee's name here: Surname: <u></u> Forenames: <u></u>			
Birth date: <u>16/01/1999</u>		Nationality: <u>India</u>	
Country of birth: <u>India</u>		Religion: <u>Sikh</u>	
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		<input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced	
Relationship to employee <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter		Number of children: <u>2</u>	
Reason for examination Pre-Employment <input type="checkbox"/> Job: Pre-Overseas <input type="checkbox"/> Area: <u></u>			
Name and address of family doctor		List your last 3 jobs	
		(1) <u></u>	
		(2) <u></u>	
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 <input checked="" type="checkbox"/>		21. Cancer <input checked="" type="checkbox"/>	
2. Neck swelling/glands <input checked="" type="checkbox"/>		22. Heart Disease <input checked="" type="checkbox"/>	
3. Difficulty in vision <input checked="" type="checkbox"/>		23. Rheumatic fever <input checked="" type="checkbox"/>	
4. Any ear discharge <input checked="" type="checkbox"/>		24. Abnormal heartbeat <input checked="" type="checkbox"/>	
5. Asthma/bronchitis <input checked="" type="checkbox"/>		25. High blood pressure <input checked="" type="checkbox"/>	
6. Hayfever /other significant allergy <input checked="" type="checkbox"/>		26. Stroke <input checked="" type="checkbox"/>	
7. Any skin trouble <input checked="" type="checkbox"/>		27. Serious chest pain <input checked="" type="checkbox"/>	
8. Tuberculosis <input checked="" type="checkbox"/>		28. Any blood disease <input checked="" type="checkbox"/>	
9. Shortness of breath <input checked="" type="checkbox"/>		29. Kidney disease <input checked="" type="checkbox"/>	
10. Coughed/vomited blood <input checked="" type="checkbox"/>		30. Blood in urine <input checked="" type="checkbox"/>	
11. Severe abdominal pain <input checked="" type="checkbox"/>		31. Diabetes <input checked="" type="checkbox"/>	
12. Stomach ulcer <input checked="" type="checkbox"/>		32. Headaches/migraine <input checked="" type="checkbox"/>	
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"/>			
<div style="display: flex; justify-content: space-between;"> How much tobacco each day? <u>NO</u> Average daily alcohol consumption <u>occasional</u> </div>			
Have you ever taken elicited drugs? <input checked="" type="checkbox"/> 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: <u></u>		Signature of Applicant: <u>Hardeep Singh</u>	



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	BMI	B.P.
171	77	26.3	133/93
PULSE	HEARING	VISION	Colour Vision
84 /mins.	L (1) R (1)	DISTANT R L Uncorrected 6/6 6/6 Corrected	(1)
		NEAR R L 6/6 6/6	Blood Group
			O positive
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS	
✓		1. Urinalysis	
✓		2. Hb, Bloodcount, ESR	
✓		3. LFT, RFT, RBS	
		4. Drug Screen	
✓		5. Lipids (40 years +)	
✓		6. Sickie Cell test	
		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.)			
ASSESSMENT:			
<input checked="" type="checkbox"/> FIT ALL AREAS <input type="checkbox"/> FIT WITH RESTRICTION <input type="checkbox"/> TEMPORARY UNFIT <input type="checkbox"/> UNFIT			
Date: 17/11/2022 Name (Block Capitals): Dr. / Nurse Signature: DR. SHIVA KUMAR SODAIH nmc speciality hospital, Al Hail			
REVIEW/CONSULTATION			
Date: Name (Block Capitals): Dr. / Nurse Signature:			