

Medical Examination Report (EX1)



Petroleum Development Oman
MEDICAL DEPARTMENT

INITIAL EXAMINATION REPORT

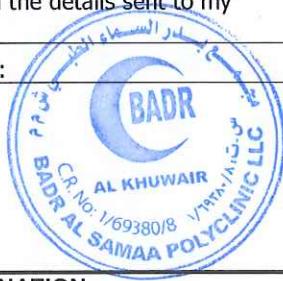
Place of examination BADR AL SAMAA	Date :- 08/ 01 / 2020	Surname <i>ISSA SAID AL BESAIID</i>			
		Forenames <i>AI Sayyid ishag</i>			
		Address <i>... 1000</i>			
		Home telephone number <i>... 1000</i>			
If a dependant or fiancée enter employee's name here:					
Surname: <i>... 1000</i> Forenames: <i>... 1000</i>					
Birth date: / /	Nationality: <i>... 1000</i>	Country of birth: <i>... 1000</i>			
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Single <input type="checkbox"/> Widow (e)	Relationship to employee				
<input type="checkbox"/> Female <input checked="" 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 checked="" type="checkbox"/> Employment				
	<input type="checkbox"/> Re-overseas				
Name and address of family doctor	List your last 3 jobs				
	(1)				
	(2)				
	(3)				
Are you a Registered Disabled Person? (UK only) []	Do you belong to any Medical Insurance Scheme? []				
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	Y <input type="checkbox"/> N <input type="checkbox"/>
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	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>
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	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>
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	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>
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	<input checked="" type="checkbox"/>	30. Painful passage of urine	<input checked="" type="checkbox"/>	FOR WOMEN ONLY	
10. Coughed/vomited blood	<input checked="" type="checkbox"/>	31. Blood in urine	<input checked="" type="checkbox"/>	Have you ever had:-	
11. Severe abdominal pain	<input checked="" type="checkbox"/>	32. Diabetes	<input checked="" type="checkbox"/>	46. An abnormal smear	
12. Stomach ulcer	<input checked="" type="checkbox"/>	33. Headaches/migraine	<input checked="" type="checkbox"/>	47. Any gynaecological treatment	
13. Recurrent indigestion	<input checked="" type="checkbox"/>	34. Dizziness/fainting	<input checked="" type="checkbox"/>	48. Are you pregnant?	
14. Jaundice or hepatitis	<input checked="" type="checkbox"/>	35. Epilepsy	<input checked="" type="checkbox"/>	49. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE	
15. Gall Bladder disease	<input checked="" type="checkbox"/>	36. Joints/spinal trouble	<input checked="" type="checkbox"/>		
16. Marked change in bowel habits	<input checked="" type="checkbox"/>	37. Surgical operation	<input checked="" type="checkbox"/>		
17. Blood in stools (motions)	<input checked="" type="checkbox"/>	38. Serious accident/fracture	<input checked="" type="checkbox"/>		
18. Marked change in weight	<input checked="" type="checkbox"/>	39. Tropical disease	<input checked="" type="checkbox"/>		
19. Varicose veins	<input checked="" type="checkbox"/>	40. Fear of heights	<input checked="" type="checkbox"/>		
20. Lump in breast/armpit	<input checked="" type="checkbox"/>	41. Rejected for employment	<input checked="" type="checkbox"/>		
21. Cancer	<input checked="" type="checkbox"/>	or insurance for medical reasons			
How much tobacco each day?			Average daily alcohol consumption		
FAMILY HISTORY Diabetes <input checked="" 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 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.					

Date: *8/11/20*

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	
	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	