

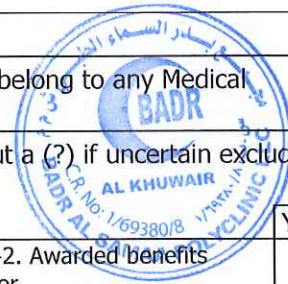
Medical Examination Report (EX1)



**Petroleum Development Oman
MEDICAL DEPARTMENT**

INITIAL EXAMINATION REPORT

Place of examination BADR AL SAMAA		Date : - 08/ 01 / 2020		Surname Issa Said al Bursaidi		Forenames Al Sayid Isay		Address	
				Home telephone number					
If a dependant or fiancée enter employee's name here:									
Surname:				Forenames:					
Birth date: / /		Nationality:		Country of birth:		Religion:			
<input checked="" type="checkbox"/> Male	<input type="checkbox"/> Single	<input type="checkbox"/> Widow (e)	Relationship to employee				Number of children		
<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		Job:-				
			<input type="checkbox"/> re-overseas		Area:-				
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.)									
	Y	N		Y	N		Y	N	
1. Sinus trouble		<input checked="" type="checkbox"/>	22. Heart Disease		<input checked="" type="checkbox"/>	42. Awarded benefits for industrial injury/illness			
2. Neck swelling/glands		<input checked="" type="checkbox"/>	23. Rheumatic fever		<input checked="" type="checkbox"/>	43. Treated for a mental condition, eg depression			
3. Difficulty in vision		<input checked="" type="checkbox"/>	24. Abnormal heartbeat		<input checked="" type="checkbox"/>	44. Treated for problem drinking or drug abuse			
4. Any ear discharge		<input checked="" type="checkbox"/>	25. High blood pressure		<input checked="" type="checkbox"/>	45. Exposed to toxic substance or noise			
5. Asthma/bronchitis		<input checked="" type="checkbox"/>	26. Stroke		<input checked="" type="checkbox"/>				
6. Hayfever/other allergy		<input checked="" type="checkbox"/>	27. Serious chest pain		<input checked="" type="checkbox"/>				
7. Any skin trouble		<input checked="" type="checkbox"/>	28. Any blood disease		<input checked="" type="checkbox"/>				
8. Tuberculosis		<input checked="" type="checkbox"/>	29. Kidney disease		<input checked="" 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"/>	HAVE YOU EVER BEEN:-	<input checked="" type="checkbox"/>			
21. Cancer	<input checked="" type="checkbox"/>	41. Rejected for employment or insurance for medical reasons	<input checked="" type="checkbox"/>			
How much tobacco each day?			Average daily alcohol consumption			
FAMILY HISTORY Diabetes []			Tuberculosis [] Epilepsy [] Asthma []			
Eczema []			Heart disease [] High blood pressure [] Stroke [] Cancer []			
[] Blood Disease []						
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: 8/1/20			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

