

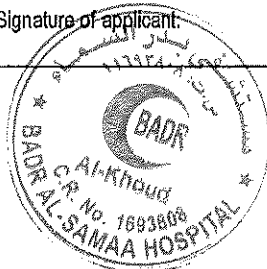
PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS



Petroleum Development Oman
MEDICAL DEPARTMENT

INITIAL EXAMINATION REPORT

| | | | | | |
|---|---|---|--|-------------------------------------|-------------------------------------|
| Place of examination BADR AL SAMAA HOSPITAL AL KHOUD BRANCH | | Date:- 28 / 01 / 2020 | | Surname HAMOOD SALIM AL NADHAIRI | |
| | | | | Forenames AL MUNTASIR | |
| | | | | Address | |
| | | | | Home Telephone Number 96764541 | |
| If a dependant or partner enter employee's name here:- Surname: Forenames: | | | | | |
| Birth date 13 / 08 / 1999 | | 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 | | <input checked="" type="checkbox"/> | 22. Heart Disease | | <input checked="" type="checkbox"/> |
| 2. Neck swelling/glands | | <input checked="" type="checkbox"/> | 23. Rheumatic fever | | <input checked="" type="checkbox"/> |
| 3. Difficulty in vision | | <input checked="" type="checkbox"/> | 24. Abnormal heartbeat | | <input checked="" type="checkbox"/> |
| 4. Any ear discharge | | <input checked="" type="checkbox"/> | 25. High blood pressure | | <input checked="" type="checkbox"/> |
| 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"/> |
| 10. Coughed/vomited blood | | <input checked="" type="checkbox"/> | 31. Blood in urine | | <input checked="" type="checkbox"/> |
| 11. Severe abdominal pain | | <input checked="" type="checkbox"/> | 32. Diabetes | | <input checked="" type="checkbox"/> |
| 12. Stomach ulcer | | <input checked="" type="checkbox"/> | 33. Headaches/migraine | | <input checked="" type="checkbox"/> |
| 13. Recurrent indigestion | | <input checked="" type="checkbox"/> | 34. Dizziness/fainting | | <input checked="" type="checkbox"/> |
| 14. Jaundice or hepatitis | | <input checked="" type="checkbox"/> | 35. Epilepsy | | <input checked="" type="checkbox"/> |
| 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/arm/pit | | <input checked="" type="checkbox"/> | HAVE YOU EVER BEEN:- | | |
| 21. Cancer | | <input checked="" type="checkbox"/> | 41. Rejected for employment or insurance for medical reasons | | <input checked="" type="checkbox"/> |
| 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: 28.01.2020 | | 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 | | | | | | | | | | | | | | | | | |
|---|---|---------------------------------------|-----------------|------------------------|--|-------------------|--|------------------------------------|--|------------------------------------|--|---|---|-------------------|--|-----------------------------|--|----------------|--|
| ✓ | | 1. Eyes & Pupils | REPORT ATTACHED | | | | | | | | | | | | | | | | |
| ✓ | | 2. E.N.T. | REPORT 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 160 | | WEIGHT kg 57 | | B.P. 120/80 mmHG | | PULSE 64/Mints | | HEARING L 13.3dBHL R 15 dBHL | | 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 | | | | | | 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
 ☐ UNFIT/UNSUITABLE
 ☐ MAY BE REASSESSED

28.01.2020

Date

Signature

DR ATMA S RAJ

Name (Block Capitals)

Doctor/Sister

REVIEW/CONSULTATION

Date

Signature

Name (Block Capitals)

Doctor/Sister

