

## 1.1 Appendix 32: EX1 Form (Initial Examination Report)

(19)

### INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

 <p>Petroleum Development Oman MEDICAL DEPARTMENT</p> <p>PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS</p>		Surname <u>Ajish Bhaskaran</u> Forenames Address Home telephone number Employment No # <u>6363</u>																																																																																																
Place of examination <u>Adan</u>	Date <u>29/3/19</u>																																																																																																	
If a dependant enter employee's name here: Surname: _____ Forenames: _____ Birth date: <u>1-5-79</u> Nationality: <u>India</u> Country of birth: _____ Religion: _____ <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female <input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced <input checked="" type="checkbox"/> Relationship to employee <input type="checkbox"/> Wife <input checked="" type="checkbox"/> Son <input checked="" type="checkbox"/> Daughter Number of children: <u>2</u>																																																																																																		
Reason for examination	Pre-Employment <input type="checkbox"/>	Job: <u>Mechanic</u>																																																																																																
	Pre-Overseas <input type="checkbox"/>	Area: _____																																																																																																
Name and address of family doctor		List your last 3 jobs (1) (2)																																																																																																
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.)																																																																																																		
<table border="1"> <thead> <tr> <th></th> <th>Y</th> <th>N</th> </tr> </thead> <tbody> <tr><td>1. Sinus trouble</td><td><input checked="" type="checkbox"/></td><td>21. Cancer</td></tr> <tr><td>2. Neck swelling/glands</td><td><input checked="" type="checkbox"/></td><td>22. Heart Disease</td></tr> <tr><td>3. Difficulty in vision</td><td><input checked="" type="checkbox"/></td><td>23. Rheumatic fever</td></tr> <tr><td>4. Any ear discharge</td><td><input checked="" type="checkbox"/></td><td>24. Abnormal heartbeat</td></tr> <tr><td>5. Asthma/bronchitis</td><td><input checked="" type="checkbox"/></td><td>25. High blood pressure</td></tr> <tr><td>6. Hayfever /other significant allergy</td><td><input checked="" type="checkbox"/></td><td>26. Stroke</td></tr> <tr><td>7. Any skin trouble</td><td><input checked="" type="checkbox"/></td><td>27. Serious chest pain</td></tr> <tr><td>8. Tuberculosis</td><td><input checked="" type="checkbox"/></td><td>28. Any blood disease</td></tr> <tr><td>9. Shortness of breath</td><td><input checked="" type="checkbox"/></td><td>29. Kidney disease</td></tr> <tr><td>10. Coughed/vomited blood</td><td><input checked="" type="checkbox"/></td><td>30. Blood in urine</td></tr> <tr><td>11. Severe abdominal pain</td><td><input checked="" type="checkbox"/></td><td>31. Diabetes</td></tr> <tr><td>12. Stomach ulcer</td><td><input checked="" type="checkbox"/></td><td>32. Headaches/migraine</td></tr> <tr><td>13. Recurrent indigestion</td><td><input checked="" type="checkbox"/></td><td>33. Dizziness/fainting</td></tr> <tr><td>14. Jaundice or hepatitis</td><td><input checked="" type="checkbox"/></td><td>34. Epilepsy</td></tr> <tr><td>15. Gall Bladder disease</td><td><input checked="" type="checkbox"/></td><td>35. Joints/spinal trouble</td></tr> <tr><td>16. Marked change in bowel habits</td><td><input checked="" type="checkbox"/></td><td>36. Surgical operation</td></tr> <tr><td>17. Blood in stools (motions)</td><td><input checked="" type="checkbox"/></td><td>37. Serious accident/fracture</td></tr> <tr><td>18. Marked change in weight</td><td><input checked="" type="checkbox"/></td><td>38. Tropical disease</td></tr> <tr><td>19. Varicose veins</td><td><input checked="" type="checkbox"/></td><td>39. Fear of heights</td></tr> <tr><td>20. Lump in breast/armpit</td><td><input checked="" type="checkbox"/></td><td></td></tr> </tbody> </table>			Y	N	1. Sinus trouble	<input checked="" type="checkbox"/>	21. Cancer	2. Neck swelling/glands	<input checked="" type="checkbox"/>	22. Heart Disease	3. Difficulty in vision	<input checked="" type="checkbox"/>	23. Rheumatic fever	4. Any ear discharge	<input checked="" type="checkbox"/>	24. Abnormal heartbeat	5. Asthma/bronchitis	<input checked="" type="checkbox"/>	25. High blood pressure	6. Hayfever /other significant allergy	<input checked="" type="checkbox"/>	26. Stroke	7. Any skin trouble	<input checked="" type="checkbox"/>	27. Serious chest pain	8. Tuberculosis	<input checked="" type="checkbox"/>	28. Any blood disease	9. Shortness of breath	<input checked="" type="checkbox"/>	29. Kidney disease	10. Coughed/vomited blood	<input checked="" type="checkbox"/>	30. Blood in urine	11. Severe abdominal pain	<input checked="" type="checkbox"/>	31. Diabetes	12. Stomach ulcer	<input checked="" type="checkbox"/>	32. Headaches/migraine	13. Recurrent indigestion	<input checked="" type="checkbox"/>	33. Dizziness/fainting	14. Jaundice or hepatitis	<input checked="" type="checkbox"/>	34. Epilepsy	15. Gall Bladder disease	<input checked="" type="checkbox"/>	35. Joints/spinal trouble	16. Marked change in bowel habits	<input checked="" type="checkbox"/>	36. Surgical operation	17. Blood in stools (motions)	<input checked="" type="checkbox"/>	37. Serious accident/fracture	18. Marked change in weight	<input checked="" type="checkbox"/>	38. Tropical disease	19. Varicose veins	<input checked="" type="checkbox"/>	39. Fear of heights	20. Lump in breast/armpit	<input checked="" type="checkbox"/>		<table border="1"> <thead> <tr> <th></th> <th>Y</th> <th>N</th> </tr> </thead> <tbody> <tr><td>40. Rejected for employment or insurance for medical reasons</td><td><input checked="" type="checkbox"/></td><td></td></tr> <tr><td>41. Awarded benefits for industrial injury/illness</td><td><input checked="" type="checkbox"/></td><td></td></tr> <tr><td>42. Treated for a mental condition, e.g. depression</td><td><input checked="" type="checkbox"/></td><td></td></tr> <tr><td>43. Treated for problem drinking or drug abuse</td><td><input checked="" type="checkbox"/></td><td></td></tr> <tr><td>44. Exposed to toxic substance or noise</td><td><input checked="" type="checkbox"/></td><td></td></tr> <tr><td colspan="3"><b>FOR WOMEN ONLY</b></td></tr> <tr><td>45. An abnormal smear</td><td><input checked="" type="checkbox"/></td><td></td></tr> <tr><td>46. Any gynaecological treatment</td><td><input checked="" type="checkbox"/></td><td></td></tr> <tr><td>47. Are you pregnant?</td><td><input checked="" type="checkbox"/></td><td></td></tr> <tr><td>48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE</td><td><input checked="" type="checkbox"/></td><td></td></tr> </tbody> </table>		Y	N	40. Rejected for employment or insurance for medical reasons	<input checked="" type="checkbox"/>		41. Awarded benefits for industrial injury/illness	<input checked="" type="checkbox"/>		42. Treated for a mental condition, e.g. depression	<input checked="" type="checkbox"/>		43. Treated for problem drinking or drug abuse	<input checked="" type="checkbox"/>		44. Exposed to toxic substance or noise	<input checked="" type="checkbox"/>		<b>FOR WOMEN ONLY</b>			45. An abnormal smear	<input checked="" type="checkbox"/>		46. Any gynaecological treatment	<input checked="" type="checkbox"/>		47. Are you pregnant?	<input checked="" type="checkbox"/>		48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE	<input checked="" type="checkbox"/>	
	Y	N																																																																																																
1. Sinus trouble	<input checked="" type="checkbox"/>	21. Cancer																																																																																																
2. Neck swelling/glands	<input checked="" type="checkbox"/>	22. Heart Disease																																																																																																
3. Difficulty in vision	<input checked="" type="checkbox"/>	23. Rheumatic fever																																																																																																
4. Any ear discharge	<input checked="" type="checkbox"/>	24. Abnormal heartbeat																																																																																																
5. Asthma/bronchitis	<input checked="" type="checkbox"/>	25. High blood pressure																																																																																																
6. Hayfever /other significant allergy	<input checked="" type="checkbox"/>	26. Stroke																																																																																																
7. Any skin trouble	<input checked="" type="checkbox"/>	27. Serious chest pain																																																																																																
8. Tuberculosis	<input checked="" type="checkbox"/>	28. Any blood disease																																																																																																
9. Shortness of breath	<input checked="" type="checkbox"/>	29. Kidney disease																																																																																																
10. Coughed/vomited blood	<input checked="" type="checkbox"/>	30. Blood in urine																																																																																																
11. Severe abdominal pain	<input checked="" type="checkbox"/>	31. Diabetes																																																																																																
12. Stomach ulcer	<input checked="" type="checkbox"/>	32. Headaches/migraine																																																																																																
13. Recurrent indigestion	<input checked="" type="checkbox"/>	33. Dizziness/fainting																																																																																																
14. Jaundice or hepatitis	<input checked="" type="checkbox"/>	34. Epilepsy																																																																																																
15. Gall Bladder disease	<input checked="" type="checkbox"/>	35. Joints/spinal trouble																																																																																																
16. Marked change in bowel habits	<input checked="" type="checkbox"/>	36. Surgical operation																																																																																																
17. Blood in stools (motions)	<input checked="" type="checkbox"/>	37. Serious accident/fracture																																																																																																
18. Marked change in weight	<input checked="" type="checkbox"/>	38. Tropical disease																																																																																																
19. Varicose veins	<input checked="" type="checkbox"/>	39. Fear of heights																																																																																																
20. Lump in breast/armpit	<input checked="" type="checkbox"/>																																																																																																	
	Y	N																																																																																																
40. Rejected for employment or insurance for medical reasons	<input checked="" type="checkbox"/>																																																																																																	
41. Awarded benefits for industrial injury/illness	<input checked="" type="checkbox"/>																																																																																																	
42. Treated for a mental condition, e.g. depression	<input checked="" type="checkbox"/>																																																																																																	
43. Treated for problem drinking or drug abuse	<input checked="" type="checkbox"/>																																																																																																	
44. Exposed to toxic substance or noise	<input checked="" type="checkbox"/>																																																																																																	
<b>FOR WOMEN ONLY</b>																																																																																																		
45. An abnormal smear	<input checked="" type="checkbox"/>																																																																																																	
46. Any gynaecological treatment	<input checked="" type="checkbox"/>																																																																																																	
47. Are you pregnant?	<input checked="" type="checkbox"/>																																																																																																	
48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE	<input checked="" type="checkbox"/>																																																																																																	
How much tobacco each day? <u>0.0</u>		Average daily alcohol consumption <u>0.0</u>																																																																																																
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:- <p>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.</p>																																																																																																		
Date: <u>29/3/19</u>	Signature of Applicant: <u>Ajish</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	BM I	B.P. 150/ 90	PULSE /mins. 76	HEARING L R	VISION DISTANT Uncorrected R 6/6 L 6/6			NEAR Corrected R 6/6 L 6/6	Colour Vision	Blood Group		
159	74.5	25.2									REMARKS			
N	A				LABORATORY AND OTHER SPECIAL INVESTIGATIONS			N	A					
		1. Urinalysis								7. Audiogram				
		2. Hb, Blood count, ESR											8. Lung Function	
		3. LFT, RFT, RBS											9. Chest X-Ray	
		4. Drug Screen											10. ECG	
		5. Lipids (40 years +)											11. CVS risk for 40 yrs. & above	
		6. Sickle Cell test											12. HIV, Hepatitis screening	

OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)

Colour vision - Abnormal - Ad ophthalmology consultant

ASSESSMENT:

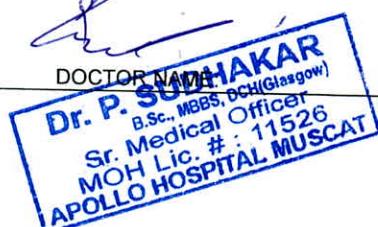
- FIT ALL AREAS
- FIT WITH SPECIFIC RESTRICTION
- TEMPORARY UNFIT
- AWAITING SPECIALIST ASSESSMENT

Type 2 DM,  
combined hyperlipidemia,  
Triglycerides,  
Ad urgent lipid profile  
(mg/dL)

~ Framingham Risk Score - 25 %

REVIEW/CONSULTATION

DATE: 01/04/19



SIGNATURE: