

# Appendix 33: EX2 Form (Routine/Periodic Medical Examination)

## ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

Petroleum Development Oman  
MEDICAL DEPARTMENT

PLEASE COMPLETE YOUR PERSONAL  
DETAILS IN BLOCK CAPITALS

Surname/Forenames **AJISH BHASKARAN KUMAR**

Nationality **INDIAN** DOB# **01/05/79**

Mobile No. **71310600**

Address: **8538 5274**

Company Number:

Reference Indicator:

### Personal Details

A ☒ Male ☐ Female

☒ Married ☐ Single ☐ Separated /Divorced /Widow(er)

Home/Leave Address:

Relationship to employee

☐ Wife ☒ Son ☒ Daughter

No of Children: **2**

Reason for Examination (tick as appropriate)

Periodic Medical Examination ☒

Final / Retirement ☐

Other Reason: ☐

### Employee only

B Present Job and Location: **MECHANIC**

Next Job and Location:

Are you a registered person with special needs? ☐

Do you belong to any Medical Insurance Scheme? ☐

**Previous Medical History:** All important medical events should be listed and dated at every medical examination. To be completed together with the interviewing Nurses or Doctor who will be able to help by referring to your notes.

Please answer the following questions and tick 'N' (no) or 'Y' (yes) in the column. If 'Y' please describe

	N	Y	Description
Have you, since your last medical been treated by your family doctor or specialist for significant (major) ailments?	✓		
1 Ear, nose, eye or throat problems	✓		
2 Chest problems like asthma, bronchitis, another bad cough	✓		
3 Heart abnormality, chest pains	✓		
4 Abdominal pains, abnormal bowel motions	✓		
5 Urogenital problems (kidney disease, menstrual disorder)	✓		
6 Skin trouble or allergies	✓		
7 Epileptic fits, dizzy spells or migraine	✓		
8 History of mental illness, depression anxiety	✓		
9 Diabetes, thyroid disease, history of Hypertension	✓		<b>DM ON MEDICATION</b>
10 Blood disorder e.g. anaemia, blood cancer e.g. leukaemia	✓		
11 Any history of accidents or fractures	✓		
12 Have you had any serious allergies	✓		
13 Do any dependants have a significant ongoing illness?	✓		
14 Any family history of cancers	✓		
Do you take any regular medicines, or have you taken in the past?	✓		<b>T Vildader 500 mg / 600 mg BD.</b>
Do you smoke? If yes, what and how much each day?	✓		
Do you drink alcohol? If yes, what is your average weekly intake?	✓		
Have you ever taken elicited/recreational drugs?	✓		
Are you doing regular sports or physical activities?	✓		

**STATEMENT:** I have read the above questions and the above answers are correct and no information concerning my present or past state of health has been withheld. I understand and agree that this form will be held as a confidential record by PDO Medical Department, and may be copied (by paper or secure electronic transmission) to the Occupational Health Services for the purpose of Health Surveillance and other Occupational Health review.

Date: **02/05/23**

Signature of Applicant: **Ajish**







Appendix 33: EX2 Form (Routine/Periodic Medical Examination)  
**ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)**

FOR COMPLETION BY EXAMINING DOCTOR OR NURSE

Further details of medical history and recreational activities

N = Normal A = Anormal (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. mmhg	PULSE /mins.	HEARING L N R N	VISION DISTANT R L NEAR R L Uncorrected Corrected	Color Vision 1. Normal 2. Abnormal
162	73	27.8	120 80	82		6/6 6/6	1. Normal 2. Abnormal

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.)**

Continue medications, follow up and do exercise.

**ASSESSMENT AND RECOMMENDATIONS:**

☒ FIT ALL AREAS ☐ FIT WITH RESTRICTION ☐ TEMPORARY UNFIT ☐ UNFIT

Date:

Name (Block Capitals): Dr. / Nurse

Signature:

**REVIEW/CONSULTATION**

Date:

Name (Block Capitals): Dr. / Nurse

Signature:

