



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 163	WEIGHT kg 79	BMI 29.7	B.P. 120/80 mmhg	PULSE 62/min.	HEARING L ✓ R ✓	VISION DISTANT R L 6/6 6/6 NEAR R L     Uncorrected Corrected	Color Vision 1. ✓ Normal 2. Abnormal
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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 +)	4.21	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.)

**ASSESSMENT AND RECOMMENDATIONS:**

FIT ALL AREAS     FIT WITH RESTRICTION     TEMPORARY UNFIT     UNFIT

Date: \_\_\_\_\_ Name (Block Capitals): Dr. / Nurse

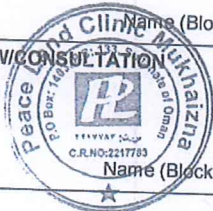
DR. FARZAD FARHAD ABBASMANESH  
 GENERAL PRACTITIONER  
 M.O.H LICENSE NO. 20379

Signature: \_\_\_\_\_

**REVIEW/CONSULTATION**

Date: \_\_\_\_\_ Name (Block Capitals): Dr. / Nurse

Signature: \_\_\_\_\_



#1945

TRUCK-OMAN - H



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

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL - CONFIDENTIAL)

18103 Reg-Dt: 30/01/2023

AJAYKUMAR VAL THARA

Male Nationality INDIAN

Petroleum Development Oman MEDICAL DEPARTMENT

Surname/Forenames AJAYKUMAR VALTHARA

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Nationality INDIAN - DOB - 04/03/1973

Mobile No. 71021399

Address: 103214309

Company Number: 1945

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:

Driver - Haima

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?	<input checked="" type="checkbox"/>		
1 Ear, nose, eye or throat problems	<input checked="" type="checkbox"/>		
2 Chest problems like asthma, bronchitis, another bad cough	<input checked="" type="checkbox"/>		
3 Heart abnormality, chest pains	<input checked="" type="checkbox"/>		
4 Abdominal pains, abnormal bowel motions	<input checked="" type="checkbox"/>		
5 Urogenital problems (kidney disease, menstrual disorder)	<input checked="" type="checkbox"/>		
6 Skin trouble or allergies	<input checked="" type="checkbox"/>		
7 Epileptic fits, dizzy spells or migraine	<input checked="" type="checkbox"/>		
8 History of mental illness, depression anxiety	<input checked="" type="checkbox"/>		
9 Diabetes, thyroid disease, history of Hypertension	<input checked="" type="checkbox"/>		
10 Blood disorder e.g. anaemia, blood cancer e.g. leukaemia	<input checked="" type="checkbox"/>		
11 Any history of accidents or fractures	<input checked="" type="checkbox"/>		
12 Have you had any serious allergies	<input checked="" type="checkbox"/>		
13 Do any dependants have a significant ongoing illness?	<input checked="" type="checkbox"/>		
14 Any family history of cancers	<input checked="" type="checkbox"/>		
Do you take any regular medicines, or have your taken in the past?	<input checked="" type="checkbox"/>		
Do you smoke? If yes, what and how much each day?	<input checked="" type="checkbox"/>		
Do you drink alcohol? If yes, what is your average weekly intake?	<input checked="" type="checkbox"/>		
Have you ever taken elicited/recreational drugs?	<input checked="" type="checkbox"/>		
Are you doing regular sports or physical activities?	<input checked="" type="checkbox"/>		

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:

30-01-2023

Signature of Applicant:

