

# 6442

(9)

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

## INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

Petroleum Development Oman  
MEDICAL DEPARTMENTPLEASE COMPLETE YOUR PERSONAL  
DETAILS IN BLOCK CAPITALS

Place of examination <u>Adam</u>		Date <u>29/3/19</u>	Surname <u>NISAM SULAIMAN</u>
			Forenames
			Address
			Home telephone number
			Employment No # <u>6442</u>

If a dependant enter employee's name here:

Surname:		Forenames:	
Birth date: <u>15-5-1984</u>	Nationality: <u>Indian</u>	Country of birth:	Religion:

☐ Male ☐ Female   
 ☐ Married ☐ Single ☐ Separated /Divorced   
 Relationship to employee: ☒ Wife ☐ Son ☐ Daughter   
 Number of children:

Reason for examination: Pre-Employment ☐ Job: Rigger  
 Pre-Overseas ☐ Area:

Name and address of family doctor	List your last 3 jobs
	(1)
	(2)

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"/>	21. Cancer		<input checked="" type="checkbox"/>	HAVE YOU EVER BEEN:-		
2. Neck swelling/glands		<input checked="" type="checkbox"/>	22. Heart Disease		<input checked="" type="checkbox"/>	40. Rejected for employment or insurance for medical reasons		<input checked="" type="checkbox"/>
3. Difficulty in vision		<input checked="" type="checkbox"/>	23. Rheumatic fever		<input checked="" type="checkbox"/>	41. Awarded benefits for industrial injury/illness		<input checked="" type="checkbox"/>
4. Any ear discharge		<input checked="" type="checkbox"/>	24. Abnormal heartbeat		<input checked="" type="checkbox"/>	42. Treated for a mental condition, e.g. depression		<input checked="" type="checkbox"/>
5. Asthma/bronchitis		<input checked="" type="checkbox"/>	25. High blood pressure		<input checked="" type="checkbox"/>	43. Treated for problem drinking or drug abuse		<input checked="" type="checkbox"/>
6. Hayfever /other significant allergy		<input checked="" type="checkbox"/>	26. Stroke		<input checked="" type="checkbox"/>	44. Exposed to toxic substance or noise		<input checked="" type="checkbox"/>
7. Any skin trouble		<input checked="" type="checkbox"/>	27. Serious chest pain		<input checked="" type="checkbox"/>	FOR WOMEN ONLY		
8. Tuberculosis		<input checked="" type="checkbox"/>	28. Any blood disease		<input checked="" type="checkbox"/>	Have you ever had:-		
9. Shortness of breath		<input checked="" type="checkbox"/>	29. Kidney disease		<input checked="" type="checkbox"/>	45. An abnormal smear		<input checked="" type="checkbox"/>
10. Coughed/vomited blood		<input checked="" type="checkbox"/>	30. Blood in urine		<input checked="" type="checkbox"/>	46. Any gynaecological treatment		<input checked="" type="checkbox"/>
11. Severe abdominal pain		<input checked="" type="checkbox"/>	31. Diabetes		<input checked="" type="checkbox"/>	47. Are you pregnant?		<input checked="" type="checkbox"/>
12. Stomach ulcer		<input checked="" type="checkbox"/>	32. Headaches/migraine		<input checked="" type="checkbox"/>	48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE		<input checked="" type="checkbox"/>
13. Recurrent indigestion		<input checked="" type="checkbox"/>	33. Dizziness/fainting		<input checked="" type="checkbox"/>			
14. Jaundice or hepatitis		<input checked="" type="checkbox"/>	34. Epilepsy		<input checked="" type="checkbox"/>			
15. Gall Bladder disease		<input checked="" type="checkbox"/>	35. Joints/spinal trouble		<input checked="" type="checkbox"/>			
16. Marked change in bowel habits		<input checked="" type="checkbox"/>	36. Surgical operation		<input checked="" type="checkbox"/>			
17. Blood in stools (motions)		<input checked="" type="checkbox"/>	37. Serious accident/fracture		<input checked="" type="checkbox"/>			
18. Marked change in weight		<input checked="" type="checkbox"/>	38. Tropical disease		<input checked="" type="checkbox"/>			
19. Varicose veins		<input checked="" type="checkbox"/>	39. Fear of heights		<input checked="" type="checkbox"/>			
20. Lump in breast/armpit		<input checked="" type="checkbox"/>						

How much tobacco each day? no Average daily alcohol consumption 25-30 gms per week

Have you ever taken elicited drugs? ( ) PDO test all new/potential employees for elicited/recreational drugs

FAMILY HISTORY: Diabetes ( ) Tuberculosis ( ) Epilepsy ( ) Asthma ( ) Eczema ( )  
Heart disease ( ) High blood pressure ( ) Stroke ( ) Blood Disease ( ) Cancer ( )

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. I am also aware that PDO reserve the right to dismiss me if it was found that I have purposely withheld important medical information.

Date: 29/3/19 Signature of Applicant: [Signature]



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.	PULSE /mins.	HEARING L R	VISION DISTANT NEAR Uncorrected Corrected	Colour Vision	Blood Group
164	65.5	24.17	120/80	78		R 6/6 L 6/6 R 4/6 L 4/6	✓	

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. Sickie Cell test		12. HIV, Hepatitis screening

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

FROMMANN Div Score: 2 1/2

ASSESSMENT:

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

REVIEW/CONSULTATION

DATE: 02/04/19

DOCTOR NAME

**Dr. P. SUBHAKAR**  
B.Sc., MBBS, DCH (Glasgow)  
Sr. Medical Officer  
MOH Lic. #: 11526  
APOLLO HOSPITAL MUSCAT

SIGNATURE: