

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

### INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)



Petroleum Development Oman  
MEDICAL DEPARTMENT

PLEASE COMPLETE YOUR PERSONAL  
DETAILS IN BLOCK CAPITALS

Place of examination		Date:-		Surname	
				Forenames	
				Address	
				Home telephone number	
				Employment No #	
If a dependant enter employee's name here:					
Surname:		Forenames:			
Birth date:	Nationality:		Country of birth:		Religion:
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced		<input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter		Number of children:
Reason for examination	Pre-Employment	<input type="checkbox"/> Job:			
	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.)					
Y		N		Y	
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	
3. Difficulty in vision		<input checked="" type="checkbox"/> 23. Rheumatic fever		<input checked="" type="checkbox"/> 41. Awarded benefits for industrial injury/illness	
4. Any ear discharge		<input checked="" type="checkbox"/> 24. Abnormal heartbeat		<input checked="" type="checkbox"/> 42. Treated for a mental condition, e.g. depression	
5. Asthma/bronchitis		<input checked="" type="checkbox"/> 25. High blood pressure		<input checked="" type="checkbox"/> 43. Treated for problem drinking or drug abuse	
6. Hayfever /other significant allergy		<input checked="" type="checkbox"/> 26. Stroke		<input checked="" type="checkbox"/> 44. Exposed to toxic substance or noise	
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	
10. Coughed/vomited blood		<input checked="" type="checkbox"/> 30. Blood in urine		<input checked="" type="checkbox"/> 46. Any gynaecological treatment	
11. Severe abdominal pain		<input checked="" type="checkbox"/> 31. Diabetes		<input checked="" type="checkbox"/> 47. Are you pregnant?	
12. Stomach ulcer		<input checked="" type="checkbox"/> 32. Headaches/migraine		<input checked="" type="checkbox"/> 48. HAVE YOU HAD AN ILLNESS	
13. Recurrent indigestion		<input checked="" type="checkbox"/> 33. Dizziness/fainting		<input checked="" type="checkbox"/> NOT MENTIONED ABOVE	
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					
How much tobacco each day?		Average daily alcohol consumption			
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: <u>7/2/2021</u>		Signature of Applicant: <u>38</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		
<input checked="" type="checkbox"/>		1. Eyes & Pupils	
<input checked="" type="checkbox"/>		2. E.N.T.	
<input checked="" type="checkbox"/>		3. Teeth & Mouth	
<input checked="" type="checkbox"/>		4. Lungs & Chest	
<input checked="" type="checkbox"/>		5. Cardiovascular System	
<input checked="" type="checkbox"/>		6. Abdo. Viscera	<i>unremarkable</i>
<input checked="" type="checkbox"/>		7. Hernial Orifices	
<input checked="" type="checkbox"/>		8. Anus & Rectum	
<input checked="" type="checkbox"/>		9. Genito-urinary	
<input checked="" type="checkbox"/>		10. Extremities	
<input checked="" type="checkbox"/>		11. Musculo-skeletal	
<input checked="" type="checkbox"/>		12. Skin & Varicose Vns.	
		13. C.N.S.	

HEIGHT cm	WEIGHT kg	BM I	B.P. 138 90	PULSE /mins. 60	HEARING L R	VISION DISTANT R L Uncorrected Corrected	NEAR R L	Colour Vision	Blood Group
166	49								

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.)

ASSESSMENT:

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

REVIEW/CONSULTATION

DATE:

DOCTOR NAME:

Dr. Ali Husaini

SIGNATURE

