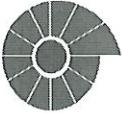


## 1.1 Appendix 32: EX1 Form (Initial Examination Report)

### INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

 <b>Petroleum Development Oman MEDICAL DEPARTMENT</b> PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS		Surname <b>AL BALUSHI</b> Forenames <b>MOHAMMED YOUSUF JAMIL</b> Address Home telephone number Employment No #																																																					
Place of examination <b>NMC AL HAIL</b>	Date:- <b>18-05-2021</b>																																																						
If a dependant enter employee's name here: Surname: <b> </b> Forenames: <b> </b> Birth date: <b>26-03-1995</b> Nationality: <b>OMAN</b> Country of birth: <b> </b> Religion: <b> </b> <input checked="" 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 Relationship to employee Number of children: <b> </b>																																																							
Reason for examination Pre-Employment <input type="checkbox"/> Job: Pre-Overseas <input type="checkbox"/> Area:																																																							
Name and address of family doctor (1) (2)		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>Y</th> <th>N</th> </tr> </thead> <tbody> <tr><td><input checked="" type="checkbox"/></td><td>21. Cancer</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>22. Heart Disease</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>23. Rheumatic fever</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>24. Abnormal heartbeat</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>25. High blood pressure</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>26. Stroke</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>27. Serious chest pain</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>28. Any blood disease</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>29. Kidney disease</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>30. Blood in urine</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>31. Diabetes</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>32. Headaches/migraine</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>33. Dizziness/fainting</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>34. Epilepsy</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>35. Joints/spinal trouble</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>36. Surgical operation</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>37. Serious accident/fracture</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>38. Tropical disease</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>39. Fear of heights</td></tr> </tbody> </table>		Y	N	<input checked="" type="checkbox"/>	21. Cancer	<input checked="" type="checkbox"/>	22. Heart Disease	<input checked="" type="checkbox"/>	23. Rheumatic fever	<input checked="" type="checkbox"/>	24. Abnormal heartbeat	<input checked="" type="checkbox"/>	25. High blood pressure	<input checked="" type="checkbox"/>	26. Stroke	<input checked="" type="checkbox"/>	27. Serious chest pain	<input checked="" type="checkbox"/>	28. Any blood disease	<input checked="" type="checkbox"/>	29. Kidney disease	<input checked="" type="checkbox"/>	30. Blood in urine	<input checked="" type="checkbox"/>	31. Diabetes	<input checked="" type="checkbox"/>	32. Headaches/migraine	<input checked="" type="checkbox"/>	33. Dizziness/fainting	<input checked="" type="checkbox"/>	34. Epilepsy	<input checked="" type="checkbox"/>	35. Joints/spinal trouble	<input checked="" type="checkbox"/>	36. Surgical operation	<input checked="" type="checkbox"/>	37. Serious accident/fracture	<input checked="" type="checkbox"/>	38. Tropical disease	<input checked="" type="checkbox"/>	39. Fear of heights	<table border="1"> <thead> <tr> <th>Y</th> <th>N</th> </tr> </thead> <tbody> <tr><td><input checked="" type="checkbox"/></td><td>40. Rejected for employment or insurance for medical reasons</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>41. Awarded benefits for industrial injury/illness</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>42. Treated for a mental condition, e.g. depression</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>43. Treated for problem drinking or drug abuse</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>44. Exposed to toxic substance or noise</td></tr> </tbody> </table>		Y	N	<input checked="" type="checkbox"/>	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
Y	N																																																						
<input checked="" type="checkbox"/>	21. Cancer																																																						
<input checked="" type="checkbox"/>	22. Heart Disease																																																						
<input checked="" type="checkbox"/>	23. Rheumatic fever																																																						
<input checked="" type="checkbox"/>	24. Abnormal heartbeat																																																						
<input checked="" type="checkbox"/>	25. High blood pressure																																																						
<input checked="" type="checkbox"/>	26. Stroke																																																						
<input checked="" type="checkbox"/>	27. Serious chest pain																																																						
<input checked="" type="checkbox"/>	28. Any blood disease																																																						
<input checked="" type="checkbox"/>	29. Kidney disease																																																						
<input checked="" type="checkbox"/>	30. Blood in urine																																																						
<input checked="" type="checkbox"/>	31. Diabetes																																																						
<input checked="" type="checkbox"/>	32. Headaches/migraine																																																						
<input checked="" type="checkbox"/>	33. Dizziness/fainting																																																						
<input checked="" type="checkbox"/>	34. Epilepsy																																																						
<input checked="" type="checkbox"/>	35. Joints/spinal trouble																																																						
<input checked="" type="checkbox"/>	36. Surgical operation																																																						
<input checked="" type="checkbox"/>	37. Serious accident/fracture																																																						
<input checked="" type="checkbox"/>	38. Tropical disease																																																						
<input checked="" type="checkbox"/>	39. Fear of heights																																																						
Y	N																																																						
<input checked="" type="checkbox"/>	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																																																						
<b>FOR WOMEN ONLY</b> Have you ever had:- 45. An abnormal smear 46. Any gynaecological treatment 47. Are you pregnant? 48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE																																																							
How much tobacco each day? <b>NO</b>		Average daily alcohol consumption <b>NO</b>																																																					
Have you ever taken elicited drugs? <input checked="" type="checkbox"/> PDO test all new/potential employees for elicited/recreational drugs																																																							
<b>FAMILY HISTORY:</b> 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"/>																																																							
<b>PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT:-</b> 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: <b>18/5/2021</b>		Signature of Applicant: 																																																					

**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 181 cm		WEIGHT 56 kg	BM 17	B.P. 131/92	PULSE 80 /mins.	HEARING L R	VISION DISTANT Uncorrected Corrected		R 6/6	L 6/6	NEAR R 6/6	L 6/6	Colour Vision	Blood Group	
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.)**

History - Re-current - Epistaxis (Nasal bleed)

**ASSESSMENT:**

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

**REVIEW/CONSULTATION**

DATE: 21/5/2021

DOCTOR NAME: Dr. Christine



Dr. STINE MANDOH LOTFY ABDALLA  
General Practitioner  
MOH Lic. No: 17978  
nmc specialty hospital, Al Hail

SIGNATURE: 