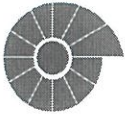


1.1 Appendix 32: EX1 Form (Initial Examination Report)

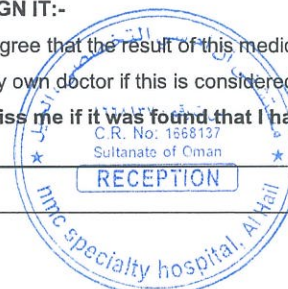
INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)



Petroleum Development Oman
MEDICAL DEPARTMENT

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Place of examination NMC AL - HAIL		Date:- 08/06/2021		Surname SOHAN LAL	
				Forenames KULDIP KUMAR	
				Address	
				Home telephone number	
				Employment No #	
If a dependant enter employee's name here:					
Surname:			Forenames:		
Birth date: 16/05/1981		Nationality: INDIAN		Country of birth: INDIA	
Religion:					
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		<input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced		Relationship to employee	
				<input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	
				Number of children: 1	
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	N
1. Sinus trouble		<input checked="" type="checkbox"/>	21. Cancer		<input checked="" type="checkbox"/>
2. Neck swelling/glands		<input checked="" type="checkbox"/>	22. Heart Disease		<input checked="" type="checkbox"/>
3. Difficulty in vision		<input checked="" type="checkbox"/>	23. Rheumatic fever		<input checked="" type="checkbox"/>
4. Any ear discharge		<input checked="" type="checkbox"/>	24. Abnormal heartbeat		<input checked="" type="checkbox"/>
5. Asthma/bronchitis		<input checked="" type="checkbox"/>	25. High blood pressure		<input checked="" type="checkbox"/>
6. Hayfever /other significant allergy		<input checked="" type="checkbox"/>	26. Stroke		<input checked="" type="checkbox"/>
7. Any skin trouble		<input checked="" type="checkbox"/>	27. Serious chest pain		<input checked="" type="checkbox"/>
8. Tuberculosis		<input checked="" type="checkbox"/>	28. Any blood disease		<input checked="" type="checkbox"/>
9. Shortness of breath		<input checked="" type="checkbox"/>	29. Kidney disease		<input checked="" type="checkbox"/>
10. Coughed/vomited blood		<input checked="" type="checkbox"/>	30. Blood in urine		<input checked="" type="checkbox"/>
11. Severe abdominal pain		<input checked="" type="checkbox"/>	31. Diabetes		<input checked="" type="checkbox"/>
12. Stomach ulcer		<input checked="" type="checkbox"/>	32. Headaches/migraine		<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 NO		
Have you ever taken elicited drugs? (NO) PDO test all new/potential employees for elicited/recreational drugs					
FAMILY HISTORY: Diabetes (N) Tuberculosis (N) Epilepsy (N) Asthma (N) Eczema (N)					
Heart disease (N) High blood pressure (N) Stroke (N) Blood Disease (N) Cancer (N)					
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: 08/06/2021		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.

Conjunctival Sclera of (R) eye.

HEIGHT	WEIGHT	BM	B.P.	PULSE	HEARING	VISION	Colour Vision	Blood Group
163 cm	96 kg	36	145/98	77/min.	L R	DISTANT NEAR Uncorrected Corrected R L R L 6/6 6/6 6/6 6/6	Normal	O+ve

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. Sick 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: 8/6/2021

DOCTOR NAME: Dr. Christine

SIGNATURE: DR. CHRISTINE MAMMOUH LOTFY ABDALLA
General Practitioner
MOH Lic. No: 17978
nmc specialty hospital, Al-Hail