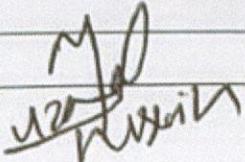


1.1 Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

 Petroleum Development Oman MEDICAL DEPARTMENT		Surname IHSAN ALI Forenames MUZAMMAL HUSSAIN Address Home telephone number Employment No #					
Place of examination	Date:-						
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 <table border="1" style="float: right; border-collapse: collapse;"> <tr> <td><input type="checkbox"/> Wife</td> <td><input type="checkbox"/> Son</td> <td><input type="checkbox"/> Daughter</td> </tr> </table>		<input type="checkbox"/> Wife	<input type="checkbox"/> Son	<input type="checkbox"/> Daughter	
<input type="checkbox"/> Wife	<input type="checkbox"/> Son	<input type="checkbox"/> Daughter					
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.)							
<table border="1" style="border-collapse: collapse; width: 100px;"> <tr> <td style="text-align: center; padding: 2px;">Y</td> <td style="text-align: center; padding: 2px;">N</td> </tr> </table>		Y	N	<table border="1" style="border-collapse: collapse; width: 100px;"> <tr> <td style="text-align: center; padding: 2px;">Y</td> <td style="text-align: center; padding: 2px;">N</td> </tr> </table>		Y	N
Y	N						
Y	N						
1. Sinus trouble		21. Cancer <input checked="" type="checkbox"/> HAVE YOU EVER BEEN:-					
2. Neck swelling/glands		22. Heart Disease <input checked="" type="checkbox"/> 23. Rheumatic fever <input checked="" type="checkbox"/>					
3. Difficulty in vision		24. Abnormal heartbeat <input checked="" type="checkbox"/> 25. High blood pressure <input checked="" type="checkbox"/>					
4. Any ear discharge		26. Stroke <input checked="" type="checkbox"/> 27. Serious chest pain <input checked="" type="checkbox"/>					
5. Asthma/bronchitis		28. Any blood disease <input checked="" type="checkbox"/> 29. Kidney disease <input checked="" type="checkbox"/>					
6. Hayfever /other significant allergy		30. Blood in urine <input checked="" type="checkbox"/> 31. Diabetes <input checked="" type="checkbox"/>					
7. Any skin trouble		32. Headaches/migraine <input checked="" type="checkbox"/> 33. Dizziness/fainting <input checked="" type="checkbox"/>					
8. Tuberculosis		34. Epilepsy <input checked="" type="checkbox"/> 35. Joints/spinal trouble <input checked="" type="checkbox"/>					
9. Shortness of breath		36. Surgical operation <input checked="" type="checkbox"/> 37. Serious accident/fracture <input checked="" type="checkbox"/>					
10. Coughed/vomited blood		38. Tropical disease <input checked="" type="checkbox"/> 39. Fear of heights <input checked="" type="checkbox"/>					
11. Severe abdominal pain		FOR WOMEN ONLY 40. Rejected for employment or insurance for medical reasons <input checked="" type="checkbox"/> 41. Awarded benefits for industrial injury/illness <input checked="" type="checkbox"/>					
12. Stomach ulcer		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"/>					
13. Recurrent indigestion		44. Exposed to toxic substance or noise <input checked="" type="checkbox"/>					
14. Jaundice or hepatitis		Have you ever had:- 45. An abnormal smear <input checked="" type="checkbox"/> 46. Any gynaecological treatment <input checked="" type="checkbox"/>					
15. Gall Bladder disease		47. Are you pregnant? <input checked="" type="checkbox"/>					
16. Marked change in bowel habits		48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE <input checked="" type="checkbox"/>					
17. Blood in stools (motions)							
18. Marked change in weight							
19. Varicose veins							
20. Lump in breast/armpit							
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 <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"/>							
PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT:- <p>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.</p>							
Date: 15.7.21		Signature of Applicant: 					

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. Hemal. 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	HEARING L R	VISION Uncorrected Corrected	DISTANT R L	NEAR R L	Colour Vision	Blood Group
180	109.2	33	137/74	74/mins.	Y/N		6/6	6/6	N	

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

DR. DINTO MATHEW
General Practitioner
MOH Lic. No. 6366
Specialty Hospital Al Ghubaiba

DATE: 15.7.21

DOCTOR NAME:

SIGNATURE: