

Copy

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 NML ALHAIL		Date:-	Surname AL HAWASI																																																																																																																															
			Forenames ABDUL SALLAM ABDULLA																																																																																																																															
			Address																																																																																																																															
			Home telephone number																																																																																																																															
			Employment No #																																																																																																																															
If a dependant enter employee's name here:																																																																																																																																		
Surname:		Forenames:																																																																																																																																
Birth date: 27/08/1974		Nationality: OMA	Country of birth:	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																																																																																																																															
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"> <tr> <th>Y</th> <th>N</th> <th>Y</th> <th>N</th> <th>Y</th> <th>N</th> </tr> <tr> <td colspan="2">1. Sinus trouble</td> <td colspan="2"><input checked="" type="checkbox"/></td> <td colspan="2">21. Cancer</td> </tr> <tr> <td colspan="2">2. Neck swelling/glands</td> <td colspan="2"><input checked="" type="checkbox"/></td> <td colspan="2">22. Heart Disease</td> </tr> <tr> <td colspan="2">3. Difficulty in vision</td> <td colspan="2"><input checked="" type="checkbox"/></td> <td colspan="2">23. Rheumatic fever</td> </tr> <tr> <td colspan="2">4. Any ear discharge</td> <td colspan="2"><input checked="" type="checkbox"/></td> <td colspan="2">24. Abnormal heartbeat</td> </tr> <tr> <td colspan="2">5. Asthma/bronchitis</td> <td colspan="2"><input checked="" type="checkbox"/></td> <td colspan="2">25. High blood pressure</td> </tr> <tr> <td colspan="2">6. Hayfever /other significant allergy</td> <td colspan="2"><input checked="" type="checkbox"/></td> <td colspan="2">26. Stroke</td> </tr> <tr> <td colspan="2">7. Any skin trouble</td> <td colspan="2"><input checked="" type="checkbox"/></td> <td colspan="2">27. Serious chest pain</td> </tr> <tr> <td colspan="2">8. Tuberculosis</td> <td colspan="2"><input checked="" type="checkbox"/></td> <td colspan="2">28. Any blood disease</td> </tr> <tr> <td colspan="2">9. Shortness of breath</td> <td colspan="2"><input checked="" type="checkbox"/></td> <td colspan="2">29. Kidney disease</td> </tr> <tr> <td colspan="2">10. Coughed/vomited blood</td> <td colspan="2"><input checked="" type="checkbox"/></td> <td colspan="2">30. Blood in urine</td> </tr> <tr> <td colspan="2">11. Severe abdominal pain</td> <td colspan="2"><input checked="" type="checkbox"/></td> <td colspan="2">31. Diabetes</td> </tr> <tr> <td colspan="2">12. Stomach ulcer</td> <td colspan="2"><input checked="" type="checkbox"/></td> <td colspan="2">32. Headaches/migraine</td> </tr> <tr> <td colspan="2">13. Recurrent indigestion</td> <td colspan="2"><input checked="" type="checkbox"/></td> <td colspan="2">33. Dizziness/fainting</td> </tr> <tr> <td colspan="2">14. Jaundice or hepatitis</td> <td colspan="2"><input checked="" type="checkbox"/></td> <td colspan="2">34. Epilepsy</td> </tr> <tr> <td colspan="2">15. Gall Bladder disease</td> <td colspan="2"><input checked="" type="checkbox"/></td> <td colspan="2">35. Joints/spinal trouble</td> </tr> <tr> <td colspan="2">16. Marked change in bowel habits</td> <td colspan="2"><input checked="" type="checkbox"/></td> <td colspan="2">36. Surgical operation</td> </tr> <tr> <td colspan="2">17. Blood in stools (motions)</td> <td colspan="2"><input checked="" type="checkbox"/></td> <td colspan="2">37. Serious accident/fracture</td> </tr> <tr> <td colspan="2">18. Marked change in weight</td> <td colspan="2"><input checked="" type="checkbox"/></td> <td colspan="2">38. Tropical disease</td> </tr> <tr> <td colspan="2">19. Varicose veins</td> <td colspan="2"><input checked="" type="checkbox"/></td> <td colspan="2">39. Fear of heights</td> </tr> <tr> <td colspan="2">20. Lump in breast/armpit</td> <td colspan="2"><input checked="" type="checkbox"/></td> <td colspan="2"></td> </tr> </table>		Y	N	Y	N	Y	N	1. Sinus trouble		<input checked="" type="checkbox"/>		21. Cancer		2. Neck swelling/glands		<input checked="" type="checkbox"/>		22. Heart Disease		3. Difficulty in vision		<input checked="" type="checkbox"/>		23. Rheumatic fever		4. Any ear discharge		<input checked="" type="checkbox"/>		24. Abnormal heartbeat		5. Asthma/bronchitis		<input checked="" type="checkbox"/>		25. High blood pressure		6. Hayfever /other significant allergy		<input checked="" type="checkbox"/>		26. Stroke		7. Any skin trouble		<input checked="" type="checkbox"/>		27. Serious chest pain		8. Tuberculosis		<input checked="" type="checkbox"/>		28. Any blood disease		9. Shortness of breath		<input checked="" type="checkbox"/>		29. Kidney disease		10. Coughed/vomited blood		<input checked="" type="checkbox"/>		30. Blood in urine		11. Severe abdominal pain		<input checked="" type="checkbox"/>		31. Diabetes		12. Stomach ulcer		<input checked="" type="checkbox"/>		32. Headaches/migraine		13. Recurrent indigestion		<input checked="" type="checkbox"/>		33. Dizziness/fainting		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		<input checked="" type="checkbox"/>				HAVE YOU EVER BEEN:- 40. Rejected for employment or insurance for medical reasons 41. Awarded benefits for industrial injury/illness 42. Treated for a mental condition, e.g. depression 43. Treated for problem drinking or drug abuse 44. Exposed to toxic substance or noise FOR WOMEN ONLY 45. An abnormal smear 46. Any gynaecological treatment 47. Are you pregnant? 48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE		
Y	N	Y	N	Y	N																																																																																																																													
1. Sinus trouble		<input checked="" type="checkbox"/>		21. Cancer																																																																																																																														
2. Neck swelling/glands		<input checked="" type="checkbox"/>		22. Heart Disease																																																																																																																														
3. Difficulty in vision		<input checked="" type="checkbox"/>		23. Rheumatic fever																																																																																																																														
4. Any ear discharge		<input checked="" type="checkbox"/>		24. Abnormal heartbeat																																																																																																																														
5. Asthma/bronchitis		<input checked="" type="checkbox"/>		25. High blood pressure																																																																																																																														
6. Hayfever /other significant allergy		<input checked="" type="checkbox"/>		26. Stroke																																																																																																																														
7. Any skin trouble		<input checked="" type="checkbox"/>		27. Serious chest pain																																																																																																																														
8. Tuberculosis		<input checked="" type="checkbox"/>		28. Any blood disease																																																																																																																														
9. Shortness of breath		<input checked="" type="checkbox"/>		29. Kidney disease																																																																																																																														
10. Coughed/vomited blood		<input checked="" type="checkbox"/>		30. Blood in urine																																																																																																																														
11. Severe abdominal pain		<input checked="" type="checkbox"/>		31. Diabetes																																																																																																																														
12. Stomach ulcer		<input checked="" type="checkbox"/>		32. Headaches/migraine																																																																																																																														
13. Recurrent indigestion		<input checked="" type="checkbox"/>		33. Dizziness/fainting																																																																																																																														
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		<input checked="" type="checkbox"/>																																																																																																																																
How much tobacco each day? Occasional only						Average daily alcohol consumption																																																																																																																												
Have you ever taken elicited drugs? () 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:-																																																																																																																																		
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:		Signature of Applicant:																																																																																																																																

