


1.1 Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

Copy



**Petroleum Development Oman
MEDICAL DEPARTMENT**

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Place of examination NML ALHAIL		Date:-		Surname AL HAWASI		Forenames ABOUL SALAM ABDULLA	
				Address			
				Home telephone number			
				Employment No #			

If a dependant enter employee's name here:

Surname:		Forenames:	
Birth date: 27/08/1979	Nationality: OMANI	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	Number of children:
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Reason for examination Pre-Employment ☐ Job:
Pre-Overseas ☐ Area:

Name and address of family doctor	List your last 3 jobs
	(1)
	(2)

Are you a Registered Disabled Person? (UK only) ☐ Do you belong to any Medical Insurance Scheme? ☐

DO YOU HAVE OR HAVE YOU HAD:- (Tick "Yes" or "No" column or put a (?) if uncertain exclude minor ailments.)

	Y	N		Y	N		Y	N	
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		<input checked="" type="checkbox"/>
3. Difficulty in vision		<input checked="" type="checkbox"/>	23. Rheumatic fever		<input checked="" type="checkbox"/>		41. Awarded benefits for industrial injury/illness		<input checked="" type="checkbox"/>
4. Any ear discharge		<input checked="" type="checkbox"/>	24. Abnormal heartbeat		<input checked="" type="checkbox"/>		42. Treated for a mental condition, e.g. depression		<input checked="" type="checkbox"/>
5. Asthma/bronchitis		<input checked="" type="checkbox"/>	25. High blood pressure		<input checked="" type="checkbox"/>	43. Treated for problem drinking or drug abuse		<input checked="" type="checkbox"/>	
6. Hayfever /other significant allergy		<input checked="" type="checkbox"/>	26. Stroke		<input checked="" type="checkbox"/>	44. Exposed to toxic substance or noise		<input checked="" type="checkbox"/>	
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"/>		45. An abnormal smear		
9. Shortness of breath		<input checked="" type="checkbox"/>	29. Kidney disease		<input checked="" type="checkbox"/>		46. Any gynaecological treatment		
10. Coughed/vomited blood		<input checked="" type="checkbox"/>	30. Blood in urine		<input checked="" type="checkbox"/>		47. Are you pregnant?		
11. Severe abdominal pain		<input checked="" type="checkbox"/>	31. Diabetes		<input checked="" type="checkbox"/>	48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE			
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/arnpit		<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 (X) Tuberculosis (X) Epilepsy (X) Asthma (X) Eczema (X)
Heart disease (X) High blood pressure (X) Stroke (X) Blood Disease (X) Cancer (X)

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: _____

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
<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.
<input checked="" type="checkbox"/>		13. C.N.S.

HEIGHT cm 171	WEIGHT kg 78	BM I 26.6	B.P. 129 88	PULSE 72 /mins.	HEARING L Normal R Normal	VISION DISTANT R L Uncorrected Corrected	NEAR R L Uncorrected Corrected	Colour Vision Normal	Blood Group B +ve
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N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A
<input checked="" type="checkbox"/>		1. Urinalysis	<input checked="" type="checkbox"/>	7. Audiogram
<input checked="" type="checkbox"/>		2. Hb, Blood count, ESR		8. Lung Function
<input checked="" type="checkbox"/>		3. LFT, RFT, RBS		9. Chest X-Ray
<input checked="" type="checkbox"/>		4. Drug Screen	<input checked="" type="checkbox"/>	10. ECG
<input checked="" type="checkbox"/>		5. Lipids (40 years +)		11. CVS risk for 40 yrs & above
<input checked="" type="checkbox"/>		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: 29/7/21

DOCTOR NAME: DR. MASOOD

SIGNATURE:

[Signature]