

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 <u>NMC ahail</u>		Date:- <u>10.8.2021</u>		Surname <u>KhAbir</u>	
				Forenames <u>Muhammed</u>	
				Address	
				Home telephone number	
				Employment No #	
If a dependant enter employee's name here:					
Surname:		Forenames:			
Birth date: <u>1/1/1976</u>		Nationality: <u>PAKISTAN</u>		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:					
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/areola		<input checked="" type="checkbox"/>			
HAVE YOU EVER BEEN:-					
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				<input checked="" type="checkbox"/>	
FOR WOMEN ONLY					
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? <u>Quit 1 year before</u> Average daily alcohol consumption <u>NO</u>					
Have you ever taken elicited drugs? <u>NO</u> 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: <u>[Signature]</u>			

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	WEIGHT kg	BM I	B.P.	PULSE	HEARING L R	VISION DISTANT NEAR R L R L Uncorrected Corrected	Colour Vision	Blood Group
169	86.4	30.25	111/79	73/min.	L N R N	Uncorrected 6/6 6/6 Corrected N N	Normal	"D" +ve

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		<input checked="" type="checkbox"/>		8. Lung Function
<input checked="" type="checkbox"/>		3. LFT, RFT, RBS		<input checked="" type="checkbox"/>		9. Chest X-Ray
		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. Sickie 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

Triglyceride + VLDL. need consultation by internist

DATE: 10/08/2021

DOCTOR NAME: DR. MUHAMMAD KAMRAN

SIGNATURE:

DR. MUHAMMAD KAMRAN
General Practitioner
MOH Lic. No: 7638
nmc speciality hospital, Al-Hail