

2008

## 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  |  | Date:-  | Surname   |                     |
| Name - AL-HAIL  |  | 20/05/2021  | Forenames MOHAMMED NASIRUDDIN   |                     |
| Address   |  | Home telephone number   |   |                     |
| Employment No #   |  |   |   |                     |
| If a dependant enter employee's name here:  |  |   |   |                     |
| Surname:  |  | Forenames:  |   |                     |
| Birth date:   | Nationality: BANGLADESH  | Country of birth: BANGLADESH  | Religion: MUSLIM  |                     |
| <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female  | <input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced | <input checked="" type="checkbox"/> Relationship to employee  | <input type="checkbox"/> Wife <input checked="" type="checkbox"/> Son <input type="checkbox"/> Daughter                       | Number of children: |
| Reason for examination  | Pre-Employment   | <input checked="" 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.)   |  |   |   |                     |
| 1. Sinus trouble  |  | <input checked="" type="checkbox"/> Y <input type="checkbox"/> N  | 21. Cancer <input checked="" type="checkbox"/> Y <input type="checkbox"/> N   |                     |
| 2. Neck swelling/glands   |  | <input checked="" type="checkbox"/> Y <input type="checkbox"/> N  | 22. Heart Disease <input checked="" type="checkbox"/> Y <input type="checkbox"/> N  |                     |
| 3. Difficulty in vision   |  | <input checked="" type="checkbox"/> Y <input type="checkbox"/> N  | 23. Rheumatic fever <input checked="" type="checkbox"/> Y <input type="checkbox"/> N  |                     |
| 4. Any ear discharge  |  | <input checked="" type="checkbox"/> Y <input type="checkbox"/> N  | 24. Abnormal heartbeat <input checked="" type="checkbox"/> Y <input type="checkbox"/> N                                       |                     |
| 5. Asthma/brechitis   |  | <input checked="" type="checkbox"/> Y <input type="checkbox"/> N  | 25. High blood pressure <input checked="" type="checkbox"/> Y <input type="checkbox"/> N                                      |                     |
| 6. Hayfever /other significant allergy  |  | <input checked="" type="checkbox"/> Y <input type="checkbox"/> N  | 26. Stroke <input checked="" type="checkbox"/> Y <input type="checkbox"/> N   |                     |
| 7. Any skin trouble   |  | <input checked="" type="checkbox"/> Y <input type="checkbox"/> N  | 27. Serious chest pain <input checked="" type="checkbox"/> Y <input type="checkbox"/> N                                       |                     |
| 8. Tuberculosis   |  | <input checked="" type="checkbox"/> Y <input type="checkbox"/> N  | 28. Any blood disease <input checked="" type="checkbox"/> Y <input type="checkbox"/> N  |                     |
| 9. Shortness of breath  |  | <input checked="" type="checkbox"/> Y <input type="checkbox"/> N  | 29. Kidney disease <input checked="" type="checkbox"/> Y <input type="checkbox"/> N   |                     |
| 10. Coughed/vomited blood   |  | <input checked="" type="checkbox"/> Y <input type="checkbox"/> N  | 30. Blood in urine <input checked="" type="checkbox"/> Y <input type="checkbox"/> N   |                     |
| 11. Severe abdominal pain   |  | <input checked="" type="checkbox"/> Y <input type="checkbox"/> N  | 31. Diabetes <input checked="" type="checkbox"/> Y <input type="checkbox"/> N   |                     |
| 12. Stomach ulcer   |  | <input checked="" type="checkbox"/> Y <input type="checkbox"/> N  | 32. Headaches/migraine <input checked="" type="checkbox"/> Y <input type="checkbox"/> N                                       |                     |
| 13. Recurrent indigestion   |  | <input checked="" type="checkbox"/> Y <input type="checkbox"/> N  | 33. Dizziness/fainting <input checked="" type="checkbox"/> Y <input type="checkbox"/> N                                       |                     |
| 14. Jaundice or hepatitis   |  | <input checked="" type="checkbox"/> Y <input type="checkbox"/> N  | 34. Epilepsy <input checked="" type="checkbox"/> Y <input type="checkbox"/> N   |                     |
| 15. Gall Bladder disease  |  | <input checked="" type="checkbox"/> Y <input type="checkbox"/> N  | 35. Joints/spinal trouble <input checked="" type="checkbox"/> Y <input type="checkbox"/> N                                    |                     |
| 16. Marked change in bowel habits   |  | <input checked="" type="checkbox"/> Y <input type="checkbox"/> N  | 36. Surgical operation <input checked="" type="checkbox"/> Y <input type="checkbox"/> N                                       |                     |
| 17. Blood in stools (motions)   |  | <input checked="" type="checkbox"/> Y <input type="checkbox"/> N  | 37. Serious accident/fracture <input checked="" type="checkbox"/> Y <input type="checkbox"/> N                                |                     |
| 18. Marked change in weight   |  | <input checked="" type="checkbox"/> Y <input type="checkbox"/> N  | 38. Tropical disease <input checked="" type="checkbox"/> Y <input type="checkbox"/> N   |                     |
| 19. Varicose veins  |  | <input checked="" type="checkbox"/> Y <input type="checkbox"/> N  | 39. Fear of heights <input checked="" type="checkbox"/> Y <input type="checkbox"/> N  |                     |
| 20. Lump in breast/armpit   |  | <input checked="" type="checkbox"/> Y <input type="checkbox"/> N  | HAVE YOU EVER BEEN:-  |                     |
| How much tobacco each day?  |  | <input checked="" type="checkbox"/> NO  | 40. Rejected for employment or insurance for medical reasons <input checked="" type="checkbox"/> Y <input type="checkbox"/> N |                     |
|   |  |   | 41. Awarded benefits for industrial injury/illness <input checked="" type="checkbox"/> Y <input type="checkbox"/> N           |                     |
|   |  |   | 42. Treated for a mental condition, e.g. depression <input checked="" type="checkbox"/> Y <input type="checkbox"/> N          |                     |
|   |  |   | 43. Treated for problem drinking or drug abuse <input checked="" type="checkbox"/> Y <input type="checkbox"/> N               |                     |
|   |  |   | 44. Exposed to toxic substance or noise <input checked="" type="checkbox"/> Y <input type="checkbox"/> N                      |                     |
|   |  |   | FOR WOMEN ONLY  |                     |
|   |  |   | Have you ever had:-   |                     |
|   |  |   | 45. An abnormal smear <input checked="" type="checkbox"/> Y <input type="checkbox"/> N  |                     |
|   |  |   | 46. Any gynaecological treatment <input checked="" type="checkbox"/> Y <input type="checkbox"/> N                             |                     |
|   |  |   | 47. Are you pregnant? <input checked="" type="checkbox"/> Y <input type="checkbox"/> N  |                     |
|   |  |   | 48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE <input checked="" type="checkbox"/> Y <input type="checkbox"/> N              |                     |
| Have you ever taken elicited drugs? <input type="checkbox"/>  |  | PDO test all new/potential employees for elicited/recreational drugs <input checked="" type="checkbox"/> NO |   |                     |
| FAMILY HISTORY: Diabetes <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Epilepsy <input type="checkbox"/> Asthma <input type="checkbox"/> Eczema <input type="checkbox"/><br>Heart disease <input type="checkbox"/> High blood pressure <input type="checkbox"/> Stroke <input type="checkbox"/> Blood Disease <input type="checkbox"/> Cancer <input 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:   |   |                     |



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   |    |           |                   |                |                                |     |     |  |               |             |                                  |
|  |                                | poor oral hygiene.   |    |           |                   |                |                                |     |     |  |               |             |                                  |
|  |                                | 2. E.N.T.  |    |           |                   |                |                                |     |     |  |               |             |                                  |
|  |                                | poor oral hygiene.   |    |           |                   |                |                                |     |     |  |               |             |                                  |
|  |                                | 3. Teeth & Mouth   |    |           |                   |                |                                |     |     |  |               |             |                                  |
|  |                                | poor oral hygiene.   |    |           |                   |                |                                |     |     |  |               |             |                                  |
|  |                                | 4. Lungs & Chest   |    |           |                   |                |                                |     |     |  |               |             |                                  |
|  |                                | poor oral hygiene.   |    |           |                   |                |                                |     |     |  |               |             |                                  |
|  |                                | 5. Cardiovascular System   |    |           |                   |                |                                |     |     |  |               |             |                                  |
|  |                                | poor oral hygiene.   |    |           |                   |                |                                |     |     |  |               |             |                                  |
|  |                                | 6. Abdo. Viscera   |    |           |                   |                |                                |     |     |  |               |             |                                  |
|  |                                | poor oral hygiene.   |    |           |                   |                |                                |     |     |  |               |             |                                  |
|  |                                | 7. Hernial Orifices  |    |           |                   |                |                                |     |     |  |               |             |                                  |
|  |                                | poor oral hygiene.   |    |           |                   |                |                                |     |     |  |               |             |                                  |
|  |                                | 8. Anus & Rectum   |    |           |                   |                |                                |     |     |  |               |             |                                  |
|  |                                | poor oral hygiene.   |    |           |                   |                |                                |     |     |  |               |             |                                  |
|  |                                | 9. Genito-urinary  |    |           |                   |                |                                |     |     |  |               |             |                                  |
|  |                                | poor oral hygiene.   |    |           |                   |                |                                |     |     |  |               |             |                                  |
|  |                                | 10. Extremities  |    |           |                   |                |                                |     |     |  |               |             |                                  |
|  |                                | poor oral hygiene.   |    |           |                   |                |                                |     |     |  |               |             |                                  |
|  |                                | 11. Musculo-skeletal   |    |           |                   |                |                                |     |     |  |               |             |                                  |
|  |                                | poor oral hygiene.   |    |           |                   |                |                                |     |     |  |               |             |                                  |
|  |                                | 12. Skin & Varicose Vns.   |    |           |                   |                |                                |     |     |  |               |             |                                  |
|  |                                | poor oral hygiene.   |    |           |                   |                |                                |     |     |  |               |             |                                  |
|  |                                | 13. C.N.S.   |    |           |                   |                |                                |     |     |  |               |             |                                  |
| HEIGHT<br>cm   |                                | WEIGHT<br>kg   | BM | B.P.      | PULSE<br>75/mins. | HEARING<br>L R | VISION<br>DISTANT R L NEAR R L |     |     |  | Colour Vision | Blood Group |                                  |
| 161  |                                | 56.6   | 26 | 158<br>89 |                   |                | Uncorrected<br>Corrected       | 6 6 | 6 6 |  |               |             |                                  |
| N  | A                              | LABORATORY AND OTHER SPECIAL INVESTIGATIONS                          |    |           |                   |                |                                |     |     |  |               | N           | A                                |
| ✓  |                                | 1. Urinalysis<br>high F BS, for further investigation and follow up. |    |           |                   |                |                                |     |     |  |               | ✓           | 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:  |                                |  |    |           |                   |                |                                |     |     |  |               |             |                                  |
| <input checked="" type="checkbox"/>  | FIT ALL AREAS                  |  |    |           |                   |                |                                |     |     |  |               |             |                                  |
| <input type="checkbox"/>   | FIT WITH SPECIFIC RESTRICTION  |  |    |           |                   |                |                                |     |     |  |               |             |                                  |
| <input type="checkbox"/>   | TEMPORARY UNFIT                |  |    |           |                   |                |                                |     |     |  |               |             |                                  |
| <input type="checkbox"/>   | AWAITING SPECIALIST ASSESSMENT |  |    |           |                   |                |                                |     |     |  |               |             |                                  |
| REVIEW/CONSULTATION  |                                |  |    |           |                   |                |                                |     |     |  |               |             |                                  |
| DATE: 30/12/2021   |                                | DOCTOR NAME: Dr. Christine   |    |           |                   |                |                                |     |     |  |               |             |                                  |
| SIGNATURE: DR. CHRISTINE MAMDOUH LOTFY ABDALLA<br>General Practitioner<br>MOH Lic. No: 17978<br>nmc speciality hospital, Al-Hail |                                |  |    |           |                   |                |                                |     |     |  |               |             |                                  |

