

2009

1.1 Appendix 32: EX1 Form (Initial Examination Report)

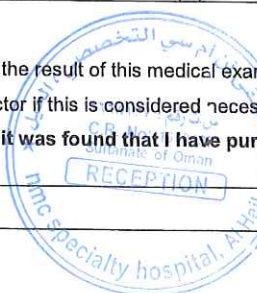
INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)



Petroleum Development Oman
MEDICAL DEPARTMENT

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Surname		Forenames		Address	
Home telephone number		Employment No #			
Place of examination		Date:-			
If a dependant enter employee's name here:					
Surname:		Forenames:			
Birth date:		Nationality: BANGLADESH		Country of birth: BANGLADESH	
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Married <input checked="" 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 checked="" type="checkbox"/> Job:		Number of children:	
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	
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? 2-3/day		Average daily alcohol consumption		NO	
Have you ever taken elicited drugs? () PDO test all new/potential employees for elicited/recreational drugs NO					
FAMILY HISTORY: Diabetes () Tuberculosis () Epilepsy () Asthma () Eczema ()					
Heart disease () High blood pressure () Stroke () Blood Disease () Cancer ()					
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
		2. E.N.T.
		3. Teeth & Mouth
		4. Lungs & Chest
		5. Cardiovascular System
		6. Abdo. Viscera
		7. Hernial 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	VISION	Colour Vision	Blood Group
164	51.2	19	126/82	73 mins.	L (N) R (N)	DISTANT R L Uncorrected 6/6 6/6 Corrected 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

DATE: 30/12/2021

DOCTOR NAME: Dr. Christine

SIGNATURE: Dr. CHRISTINE MAMDOUH LOTFY ABDALLA



General Practitioner
MOH Lic. No: 17978
nmc specialty hospital, Al-Hail