

1.1 Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

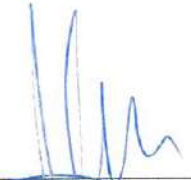


Petroleum Development Oman
MEDICAL DEPARTMENT

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Surname <u>Singh</u>					
Forenames <u>Manshon</u>					
Address					
Home telephone number <u>9169 6829</u>					
Employment No #					
Place of examination <u>Nmc Al Hail</u>	Date:- <u>06/11/2022</u>				
If a dependant onto employee's name here: Surname: Forenames:					
Birth date: <u>22/10/1958</u>	Nationality: <u>Indian</u>				
Country of birth:	Religion:				
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input 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	✓	21. Cancer	✓	HAVE YOU EVER BEEN:-	
2. Neck swelling/glands	✓	22. Heart Disease	✓	40. Rejected for employment or insurance for medical reasons	✓
3. Difficulty in vision	✓	23. Rheumatic fever	✓	41. Awarded benefits for industrial injury/illness	✓
4. Any ear discharge	✓	24. Abnormal heartbeat	✓	42. Treated for a mental condition, e.g. depression	✓
5. Asthma/bronchitis	✓	25. High blood pressure	✓	43. Treated for problem drinking or drug abuse	✓
6. Hayfever /other significant allergy	✓	26. Stroke	✓	44. Exposed to toxic substance or noise	✓
7. Any skin trouble	✓	27. Serious chest pain	✓	FOR WOMEN ONLY	
8. Tuberculosis	✓	28. Any blood disease	✓	Have you ever had:-	
9. Shortness of breath	✓	29. Kidney disease	✓	45. An abnormal smear	
10. Coughed/vomited blood	✓	30. Blood in urine	✓	46. Any gynaecological treatment	
11. Severe abdominal pain	✓	31. Diabetes	✓	47. Are you pregnant?	
12. Stomach ulcer	✓	32. Headaches/migraine	✓	48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE	
13. Recurrent indigestion	✓	33. Dizziness/fainting	✓		
14. Jaundice or hepatitis	✓	34. Epilepsy	✓		
15. Gall Bladder disease	✓	35. Joints/spinal trouble	✓		
16. Marked change in bowel habits	✓	36. Surgical operation	✓		
17. Blood in stools (motions)	✓	37. Serious accident/fracture	✓		
18. Marked change in weight	✓	38. Tropical disease	✓		
19. Varicose veins	✓	39. Fear of heights	✓		
20. Lump in breast/armpit	✓				
How much tobacco each day?		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: <u>06/11/2022</u>		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. C.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	VISION		Colour Vision	Blood Group
183	97	28.95	146/81	74/min	L R	DISTANT R L Uncorrected 6/6 6/6 Corrected	NEAR R L (N) (N)	(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					<input checked="" type="checkbox"/>		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									
<div style="display: flex; justify-content: space-between; align-items: flex-end;"> <div>DATE: 8/11/2022</div> <div>DOCTOR NAME: DR. NADIA FAHAD General Practitioner MOH Lic. No. 17683 nmc specialty hospital, Al Hail</div> <div>SIGNATURE: </div> </div>									

