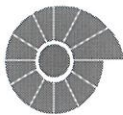



INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)



**Petroleum Development Oman
MEDICAL DEPARTMENT**

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

 Petroleum Development Oman MEDICAL DEPARTMENT		Surname	
PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS		Forenames SIMRANJIT SINGH	
		Address	
Place of examination NML ALHAIL		Home telephone number	
Date:- 05/05/2021		Employment No #	

If a dependant enter employee's name here:			
Surname:		Forenames:	
Birth date:	Nationality: INDIAN	Country of birth:	Religion:
<input 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 type="checkbox"/> Job: Pre-Overseas <input type="checkbox"/> Area:		Number of children:	
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		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 Have you ever had:-			
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/arm/pit		<input checked="" type="checkbox"/>							

How much tobacco each day? Occasional	Average daily alcohol consumption Occasional
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Have you ever taken elicited drugs? () PDO test all new/potential employees for elicited/recreational drugs

FAMILY HISTORY: Diabetes (☒ Father) 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: **5-5-21** Signature of Applicant: *[Signature]*

RECEPTION

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 170 cm	WEIGHT 95.6 kg	BM 33	B.P. 116/78	PULSE 81/min.	HEARING L N R N	VISION DISTANT R L Uncorrected 6/6 6/6 Corrected 6/6 6/6	NEAR R L 6/6 6/6	Colour Vision ✓	Blood Group A +ve
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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: 09/05/2021 DOCTOR NAME: DR. MUHAMMAD KAMRAN SIGNATURE: 

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