

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 **UML AL - MAIL** Date:-

If a dependant enter employee's name here:
Surname:

Birth date: **25/07/1980**

Nationality: **OMANI**

Surname **AHMED HUBAIS**

Forenames **MUSALLAM SALIM MAHMOUD**

Address

Home telephone number

Employment No #

Male Female

Married Single Separated /Divorced

Relationship to employee
 Wife Son Daughter

Number of
children:

Reason for examination

Pre-Employment

Job:

Name and address of family doctor

Pre-Overseas

Area:

List your last 3 jobs

(1)

(2)

Are you a Registered Disabled Person? (UK only)

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"/>	<input type="checkbox"/>	21. Cancer	<input type="checkbox"/>	<input checked="" type="checkbox"/>	HAVE YOU EVER BEEN:-		
2. Neck swelling/glands	<input checked="" type="checkbox"/>	<input type="checkbox"/>	22. Heart Disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>	40. Rejected for employment or insurance for medical reasons		
3. Difficulty in vision	<input type="checkbox"/>	<input checked="" type="checkbox"/>	23. Rheumatic fever	<input type="checkbox"/>	<input checked="" type="checkbox"/>	41. Awarded benefits for Industrial injury/illness		
4. Any ear discharge	<input type="checkbox"/>	<input checked="" type="checkbox"/>	24. Abnormal heartbeat	<input type="checkbox"/>	<input checked="" type="checkbox"/>	42. Treated for a mental condition, e.g. depression		
5. Asthma/bronchitis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	25. High blood pressure	<input type="checkbox"/>	<input checked="" type="checkbox"/>	43. Treated for problem drinking or drug abuse		
6. Hayfever /other significant allergy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	26. Stroke	<input type="checkbox"/>	<input checked="" type="checkbox"/>	44. Exposed to toxic substance or noise		
7. Any skin trouble	<input checked="" type="checkbox"/>	<input type="checkbox"/>	27. Serious chest pain	<input type="checkbox"/>	<input checked="" type="checkbox"/>	FOR WOMEN ONLY		
8. Tuberculosis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	28. Any blood disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Have you ever had:-		
9. Shortness of breath	<input type="checkbox"/>	<input checked="" type="checkbox"/>	29. Kidney disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>	45. An abnormal smear		
10. Coughed/vomited blood	<input type="checkbox"/>	<input checked="" type="checkbox"/>	30. Blood in urine	<input type="checkbox"/>	<input checked="" type="checkbox"/>	46. Any gynaecological treatment		
11. Severe abdominal pain	<input type="checkbox"/>	<input checked="" type="checkbox"/>	31. Diabetes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	47. Are you pregnant?		
12. Stomach ulcer	<input type="checkbox"/>	<input checked="" type="checkbox"/>	32. Headaches/migraine	<input type="checkbox"/>	<input checked="" type="checkbox"/>	48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE		
13. Recurrent indigestion	<input type="checkbox"/>	<input checked="" type="checkbox"/>	33. Dizziness/fainting	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
14. Jaundice or hepatitis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	34. Epilepsy	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
15. Gall Bladder disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>	35. Joints/spinal trouble	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
16. Marked change in bowel habits	<input type="checkbox"/>	<input checked="" type="checkbox"/>	36. Surgical operation	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
17. Blood in stools (motions)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	37. Serious accident/fracture	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
18. Marked change in weight	<input type="checkbox"/>	<input checked="" type="checkbox"/>	38. Tropical disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
19. Varicose veins	<input type="checkbox"/>	<input checked="" type="checkbox"/>	39. Fear of heights	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
20. Lump in breast/armpit	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>	<input checked="" type="checkbox"/>			

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 () 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		<p style="text-align: center;">SOME post appendectomy Scar. SOME</p>												
		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. 112 89	PULSE 83 /mins.	HEARING L H R N	VISION				Colour Vision	Blood Group				
179		44	13.13				Uncorrected Corrected	DISTANT R L	NEAR R L							
								6 6 6 6								
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:

DR. SHIVA KUMAR SIDDIAH
General Practitioner
MOH Lic. No. 5970
IMC Specialty Hospital, Al Hail
DOCTOR NAME:

SIGNATURE: