

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 UME AL-HAIL		Date:-		Surname AHMEAD HUBAIS	
If a dependant enter employee's name here: Surname:		Forenames MUSALLAM SALIM MAHAD		Address	
Birth date: 25/09/1986		Nationality: OMANI		Home telephone number	
Forenames:		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		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	
8. Tuberculosis	<input checked="" type="checkbox"/>	28. Any blood disease	<input checked="" type="checkbox"/>	Have you ever had:-	
9. Shortness of breath	<input checked="" type="checkbox"/>	29. Kidney disease	<input checked="" type="checkbox"/>	45. An abnormal smear	<input checked="" type="checkbox"/>
10. Coughed/vomited blood	<input checked="" type="checkbox"/>	30. Blood in urine	<input checked="" type="checkbox"/>	46. Any gynaecological treatment	<input checked="" type="checkbox"/>
11. Severe abdominal pain	<input checked="" type="checkbox"/>	31. Diabetes	<input checked="" type="checkbox"/>	47. Are you pregnant?	<input checked="" type="checkbox"/>
12. Stomach ulcer	<input checked="" type="checkbox"/>	32. Headaches/migraine	<input checked="" type="checkbox"/>	48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE	<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/armpit	<input checked="" type="checkbox"/>				
How much tobacco each day? NO		Average daily alcohol consumption NO			
Have you ever taken illicit drugs? () PDO test a new/potential employees for illicit/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 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:			

