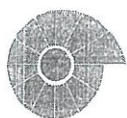


# 1.1 Appendix 32: EX1 Form (Initial Examination Report)

## INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)



Petroleum Development Oman  
MEDICAL DEPARTMENT

PLEASE COMPLETE YOUR PERSONAL  
DETAILS IN BLOCK CAPITALS

Place of examination <u>MNC - Mail</u>		Date:- <u>19/06/2022</u>		Surname	
				Forenames <u>RATIA P.</u>	
				Address	
				Home telephone number	
				Employment No #	
If a dependant enter employee's name here:					
Surname:		Forenames:			
Birth date: <u>10/01/1992</u>		Nationality: <u>BANGLA</u>		Country of birth: <u>BANGLADESH</u>	
Religion: <u>ISLAM</u>					
<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	
				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		<input checked="" type="checkbox"/>	21. Cancer		<input checked="" type="checkbox"/>
2. Neck swelling/glands		<input checked="" type="checkbox"/>	22. Heart Disease		<input checked="" type="checkbox"/>
3. Difficulty in vision		<input checked="" type="checkbox"/>	23. Rheumatic fever		<input checked="" type="checkbox"/>
4. Any ear discharge		<input checked="" type="checkbox"/>	24. Abnormal heartbeat		<input checked="" type="checkbox"/>
5. Asthma/bronchitis		<input checked="" type="checkbox"/>	25. High blood pressure		<input checked="" type="checkbox"/>
6. Hayfever /other significant allergy		<input checked="" type="checkbox"/>	26. Stroke		<input checked="" type="checkbox"/>
7. Any skin trouble		<input checked="" type="checkbox"/>	27. Serious chest pain		<input checked="" type="checkbox"/>
8. Tuberculosis		<input checked="" type="checkbox"/>	28. Any blood disease		<input checked="" type="checkbox"/>
9. Shortness of breath		<input checked="" type="checkbox"/>	29. Kidney disease		<input checked="" type="checkbox"/>
10. Coughed/vomited blood		<input checked="" type="checkbox"/>	30. Blood in urine		<input checked="" type="checkbox"/>
11. Severe abdominal pain		<input checked="" type="checkbox"/>	31. Diabetes		<input checked="" type="checkbox"/>
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/armpit		<input checked="" type="checkbox"/>			
How much tobacco each day? <u>1.5 cig/day</u>			Average daily alcohol consumption <u>1</u>		
Have you ever taken elicited drugs? ( ) PDO test all new/potential employees for elicited/recreational drugs <u>NO</u>					
FAMILY HISTORY: Diabetes ( ) Tuberculosis ( ) Epilepsy ( ) Asthma ( ) Eczema ( )					
<u>NO</u> 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: <u>[Signature]</u>			

**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 /mins.	HEARING L R	VISION DISTANT R L R L Uncorrected Corrected				Colour Vision	Blood Group
158	63	17	127 81	58	(A) (A)	6/6 6/6 6/6 6/6				(A)	
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. Sickie 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: 19/04/2022

DOCTOR NAME: DR. SHIVA KUMAR

SIGNATURE: SIDDIAH

DR. SHIVA KUMAR  
General Practitioner  
MOH Lic. No- 6470  
nmc specialty hospital. Al-Hail