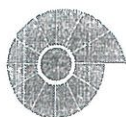


# 1.1 Appendix 32: EX1 Form (Initial Examination Report)

## INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)



Petroleum Development Oman  
MEDICAL DEPARTMENT

PLEASE COMPLETE YOUR PERSONAL  
DETAILS IN BLOCK CAPITALS

Surname		Forenames		Address	
Home telephone number		Employment No #			
Place of examination		Date:-			
If a dependant enter employee's name here:					
Surname:		Forenames:			
Birth date:		Nationality:		Country of birth:	
Religion:		Relationship to employee		Number of children:	
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Married <input checked="" type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced		<input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	
Reason for examination		Pre-Employment <input checked="" 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)		Do you belong to any Medical Insurance Scheme?			
DO YOU HAVE OR HAVE YOU HAD:- (Tick "Yes" or "No" column or put a (?) if uncertain exclude minor ailments.)					
Y		N		Y	
1. Sinus trouble		<input checked="" type="checkbox"/>		21. Cancer	
2. Neck swelling/glands		<input checked="" type="checkbox"/>		22. Heart Disease	
3. Difficulty in vision		<input checked="" type="checkbox"/>		23. Rheumatic fever	
4. Any ear discharge		<input checked="" type="checkbox"/>		24. Abnormal heartbeat	
5. Asthma/bronchitis		<input checked="" type="checkbox"/>		25. High blood pressure	
6. Hayfever /other significant allergy		<input checked="" type="checkbox"/>		26. Stroke	
7. Any skin trouble		<input checked="" type="checkbox"/>		27. Serious chest pain	
8. Tuberculosis		<input checked="" type="checkbox"/>		28. Any blood disease	
9. Shortness of breath		<input checked="" type="checkbox"/>		29. Kidney disease	
10. Coughed/vomited blood		<input checked="" type="checkbox"/>		30. Blood in urine	
11. Severe abdominal pain		<input checked="" type="checkbox"/>		31. Diabetes	
12. Stomach ulcer		<input checked="" type="checkbox"/>		32. Headaches/migraine	
13. Recurrent indigestion		<input checked="" type="checkbox"/>		33. Dizziness/fainting	
14. Jaundice or hepatitis		<input checked="" type="checkbox"/>		34. Epilepsy	
15. Gall Bladder disease		<input checked="" type="checkbox"/>		35. Joints/spinal trouble	
16. Marked change in bowel habits		<input checked="" type="checkbox"/>		36. Surgical operation	
17. Blood in stools (motions)		<input checked="" type="checkbox"/>		37. Serious accident/fracture	
18. Marked change in weight		<input checked="" type="checkbox"/>		38. Tropical disease	
19. Varicose veins		<input checked="" type="checkbox"/>		39. Fear of heights	
20. Lump in breast/armpit		<input checked="" type="checkbox"/>			
HAVE YOU EVER BEEN:-					
40. Rejected for employment or insurance for medical reasons		<input checked="" type="checkbox"/>			
41. Awarded benefits for industrial injury/illness		<input checked="" type="checkbox"/>			
42. Treated for a mental condition, e.g. depression		<input checked="" type="checkbox"/>			
43. Treated for problem drinking or drug abuse		<input checked="" type="checkbox"/>			
44. Exposed to toxic substance or noise		<input checked="" type="checkbox"/>			
FOR WOMEN ONLY					
Have you ever had:-					
45. An abnormal smear		<input type="checkbox"/>			
46. Any gynaecological treatment		<input type="checkbox"/>			
47. Are you pregnant?		<input type="checkbox"/>			
48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE		<input 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: 19/04/2022		Signature of Applicant: Riyad Hassan			

**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	HEARING	VISION				Colour Vision	Blood Group
173	52	17	102 63	68/min.	L R	DISTANT		NEAR			
						Uncorrected	R L	R L			
						Corrected					
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: 19/05/2022

DOCTOR NAME: DR. SHIVA KUMAR SINDAIAH

SIGNATURE

