



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

## INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

Petroleum Development Oman  
MEDICAL DEPARTMENTPLEASE COMPLETE YOUR PERSONAL  
DETAILS IN BLOCK CAPITALS

Place of examination <b>NML AL HAIL</b>		Date <b>27/09/22</b>	Surname <b>JOHY</b>				
			Forenames <b>SREEJITH ARKUKATTIL</b>				
			Address				
			Home telephone number				
If a dependant enter employee's name here:							
Surname:		Forenames:					
Birth date: <b>15/10/1982</b>		Nationality: <b>INDIAN</b>		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.)							
1. Sinus trouble		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	21. Cancer		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	HAVE YOU EVER BEEN:-	
2. Neck swelling/glands		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	22. Heart Disease		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	40. Rejected for employment or insurance for medical reasons	
3. Difficulty in vision		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	23. Rheumatic fever		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	41. Awarded benefits for industrial injury/illness	
4. Any ear discharge		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	24. Abnormal heartbeat		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	42. Treated for a mental condition, e.g. depression	
5. Asthma/bronchitis		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	25. High blood pressure		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	43. Treated for problem drinking or drug abuse	
6. Hayfever /other significant allergy		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	26. Stroke		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	44. Exposed to toxic substance or noise	
7. Any skin trouble		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	27. Serious chest pain		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	45. An abnormal smear	
8. Tuberculosis		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	28. Any blood disease		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	46. Any gynaecological treatment	
9. Shortness of breath		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	29. Kidney disease		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	47. Are you pregnant?	
10. Coughed/vomited blood		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	30. Blood in urine		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE	
11. Severe abdominal pain		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	31. Diabetes		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N		
12. Stomach ulcer		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	32. Headaches/migraine		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	FOR WOMEN ONLY	
13. Recurrent indigestion		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	33. Dizziness/fainting		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	Have you ever had:-	
14. Jaundice or hepatitis		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	34. Epilepsy		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	45. An abnormal smear	
15. Gall Bladder disease		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	35. Joints/spinal trouble		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	46. Any gynaecological treatment	
16. Marked change in bowel habits		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	36. Surgical operation		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	47. Are you pregnant?	
17. Blood in stools (motions)		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	37. Serious accident/fracture		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE	
18. Marked change in weight		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	38. Tropical disease		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N		
19. Varicose veins		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	39. Fear of heights		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N		
20. Lump in breast/ampull		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N					
How much tobacco each day?		Average daily alcohol consumption					
Have you ever taken illicit drugs? <input checked="" type="checkbox"/>		PDO test all new/potential employees for illicit/recreational drugs					
FAMILY HISTORY: Diabetes <input checked="" type="checkbox"/> Heart disease <input checked="" type="checkbox"/>		Tuberculosis <input checked="" type="checkbox"/> High blood pressure <input checked="" type="checkbox"/>		Epilepsy <input checked="" type="checkbox"/> Stroke <input checked="" type="checkbox"/>		Asthma <input checked="" type="checkbox"/> Blood Disease <input checked="" type="checkbox"/>	
Eczema <input checked="" type="checkbox"/> Cancer <input checked="" type="checkbox"/>							
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: <b>27/09/22</b>		Signature of Applicant:					
Page 79		Specification					
The controlled version of this CMF Document resides online in Livelink®. Printed copies are UNCONTROLLED.							





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 160	WEIGHT 78 kg	BMI 30.5	B.P. 127/93	PULSE 66 /mins.	HEARING L R	VISION Uncorrected Corrected	DISTANT R L	NEAR R L	Colour Vision	Blood Group		

N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS				N	A				
✓	1. Urinalysis					✓	7. Audiogram				
✓	2. Hb, Bloodcount, ESR <i>124</i>					✓	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.)

*liver Enzyme SGPT high.*  
*ESR HIGH.*

ASSESSMENT:

FIT ALL AREAS  FIT WITH RESTRICTION  TEMPORARY UNFIT  UNFIT

24/09/2022 - DR. MUHAMMAD KAMRAN.  
Date: Name (Block Capitals): Dr. / Nurse

Signature: *[Signature]*

REVIEW/CONSULTATION

Date: Name (Block Capitals): Dr. / Nurse



Signature: *[Signature]*