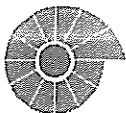
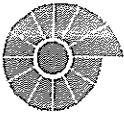


**INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)**



PLEASE COMPLETE YOUR PERSONAL  
DETAILS IN BLOCK CAPITALS

 <b>Petroleum Development Oman MEDICAL DEPARTMENT</b>		Surname <b>AL BUSAFIDI</b>	
PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS		Forenames <b>AMMAR KHAID MOHAMMED</b>	
Place of examination <b>MMU AL HAIL</b>		Address	
Date:- <b>02/11/2022</b>		Home telephone number	
If a dependant enter employee's name here:		Employment No #	
Surname		Forenames	
Birth date: <b>28/04/1994</b>		Nationality: <b>OMANI</b>	
Country of birth: <b>OMAN</b>		Religion: <b>ISLAM</b>	
<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	
Reason for examination Pre-Employment <input type="checkbox"/> Job: Pre-Overseas <input type="checkbox"/> Area:		Number of children: <b>0</b>	
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	
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"/>	
How much tobacco each day? <b>NO</b>		Average daily alcohol consumption <b>NO</b>	
Have you ever taken elicited drugs? <input checked="" type="checkbox"/> PDO test all new/potential employees for elicited/recreational drugs			
FAMILY HISTORY: Diabetes <input checked="" type="checkbox"/> Tuberculosis <input checked="" type="checkbox"/> Epilepsy <input checked="" type="checkbox"/> Asthma <input checked="" type="checkbox"/> Eczema <input checked="" type="checkbox"/> Heart disease <input checked="" type="checkbox"/> High blood pressure <input checked="" type="checkbox"/> Stroke <input checked="" type="checkbox"/> Blood Disease <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:		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	Rt. Eye 6/9, (L) Eye 6/24, inconspicuous.
✓		2. E.N.T.	
✓		3. Teeth & Mouth	
✓		4. Lungs & Chest	
✓		5. Cardiovascular System	
✓		6. Abdo. Viscera	
✓		7. Genital & Glands	
✓		8. Anus & Rectum	
✓		9. Genito-urinary	
✓		10. Extremities	
✓		11. Musculo-skeletal	
✓		12. Skin & Varicose Vns.	
✓		13. C.N.S.	

HEIGHT	WEIGHT	B.M.I.	B.P.	PULSE	HEARING	VISION	Colour Vision	Blood Group
179 cm	70 kg	21.8	126/82	60/min.	L Normal R Normal	DISTANT R 6/9 L 6/24 NEAR R N L N	Normal	

N	A		LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A	
✓		1. Urinalysis	sickle cell (+ve)	✓		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

DR. NISANTH KALLINKEEL  
Specialist - Internal Medicine  
MOH Lic. No: 16847  
nmc speciality hospital, Al-Hail

**FIT**  
7/12/2022

sickle cell (+ve) require Hb electrophoresis  
follow up with sp. Galst.

Reviewed 11/2 patient  
 - Hb electrophoresis - sickle cell trait  
 - No medication required  
 - Avoid dehydration, monitor Hb.  
 - Fit to continue work

REVIEW/CONSULTATION

DATE: 6/11/2022

DOCTOR NAME: Dr. Christa

SIGNATURE

DR. NISANTH KALLINKEEL  
Specialist - Internal Medicine  
MOH Lic. No: 16847  
nmc speciality hospital, Al-Hail