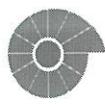




Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

Petroleum Development Oman
MEDICAL DEPARTMENTPLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAP TALSPlace of examination **NMC AL KHAIL** Date **18/04/2023**

If a dependant enter employee's name here:

Surname:

Surname **AL SHAIBAN**Forenames **MOHAMMED YOUSUF MUBARAK**

Address

Home telephone number

Birth date: 31/10/1999	Nationality: OMAN	Country of birth:	Region:
<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	Number of children:
		<input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	

Reason for examination	Pre-Employment <input checked="" type="checkbox"/>	Job: <input type="checkbox"/>
	Pre-Overseas <input type="checkbox"/>	Area: <input type="checkbox"/>

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		
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"/>		45. Have you ever had:-		
9. Shortness of breath	<input checked="" type="checkbox"/>		29. Kidney disease	<input checked="" type="checkbox"/>		46. Any gynaecological treatment		
10. Coughed/vomited blood	<input checked="" type="checkbox"/>		30. Blood in urine	<input checked="" type="checkbox"/>		47. Are you pregnant?		
11. Severe abdominal pain	<input checked="" type="checkbox"/>		31. Diabetes	<input checked="" type="checkbox"/>		48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE		
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?

Average daily alcohol consumption

Have you ever taken elicited drugs? 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"/>

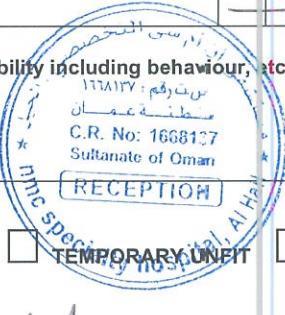
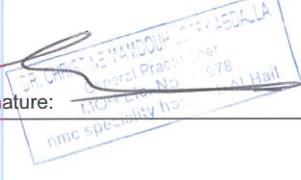
PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT:-

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									
<input checked="" type="checkbox"/>		1 Eyes & Pupils								
<input checked="" type="checkbox"/>		2 E.N.T.								
<input checked="" type="checkbox"/>		3 Teeth & Mouth								
<input checked="" type="checkbox"/>		4 Lungs & Chest								
<input checked="" type="checkbox"/>		5 Cardiovascular System								
<input checked="" type="checkbox"/>		6 Abdo. Viscera								
<input checked="" type="checkbox"/>		7 Hernial Orifices								
<input checked="" type="checkbox"/>		8 Anus & Rectum								
<input checked="" type="checkbox"/>		9 Genito-urinary								
<input checked="" type="checkbox"/>		10. Extremities								
<input checked="" type="checkbox"/>		11. Musculo-skeletal								
<input checked="" type="checkbox"/>		12. Skin & Varicose Vns.								
<input checked="" type="checkbox"/>		13. C.N.S.								
HEIGHT cm	WEIGHT kg	BMI	B.P. 120 88 /mins.	PULSE 88 /mins.	HEARING L N R N	VISION Uncorrected Corrected	DISTANT R L R N	NEAR R N N	Colour Vision	Blood Group
175	58	18.9	80						Normal	
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS				N	A			
<input checked="" type="checkbox"/>		1. Urinalysis				<input checked="" type="checkbox"/>		7. Audiogram		
<input checked="" type="checkbox"/>		2. Hb, Bloodcount, ESR				<input checked="" type="checkbox"/>		8. Lung Function		
<input checked="" type="checkbox"/>		3. LFT, RFT, RBS				<input checked="" type="checkbox"/>		9. Chest X-Ray		
<input checked="" type="checkbox"/>		4. Drug Screen				<input checked="" type="checkbox"/>		10. ECG		
<input checked="" type="checkbox"/>		5. Lipids (40 years +)				<input checked="" type="checkbox"/>		11. CVS risk for 40 yrs. & above		
<input checked="" type="checkbox"/>		6. Sickle Cell test				<input checked="" type="checkbox"/>		12. HIV Hepatitis screening		
OTHER FINDINGS (Physical, scars, disabilities, mental stability including behaviour, etc.)										
  										
ASSESSMENT:										
<input checked="" type="checkbox"/> FIT ALL AREAS		<input type="checkbox"/> FIT WITH RESTRICTION		<input type="checkbox"/> TEMPORARY UNFIT		<input type="checkbox"/> UNFIT				
Date: _____				Name (Block Capitals): Dr. / Nurse _____				Signature: _____		
REVIEW/CONSULTATION										
Date: _____				Name (Block Capitals): Dr. / Nurse _____				Signature: _____		