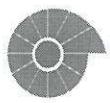


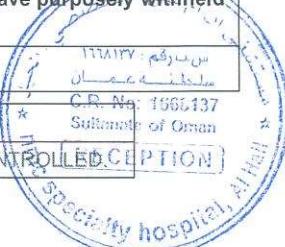


Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

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

Place of examination <i>Muscat - Hail</i>		Date <i>18/07/2022</i>	Surname <i>Al Ami</i>		
If a dependant enter employee's name here:		Forenames <i>Thumani Salim - Nai</i>			
Surname:		Address:			
Birth date: <i>06/09/1982</i>		Nationality: <i>Oman</i>	Country of birth: <i>Oman</i>	Home telephone number: <i>968 988 123456</i>	
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		<input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced	<input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	Relationship to employee <i>Daughter</i>	
Reason for examination		Pre-Employment <input type="checkbox"/> Job: <i>DRIVER</i>			
Pre-Overseas <input type="checkbox"/>		Area: <i></i>			
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"/>		21. Cancer <input type="checkbox"/>	HAVE YOU EVER BEEN:-		<input type="checkbox"/>
2. Neck swelling/glands <input checked="" type="checkbox"/>		22. Heart Disease <input type="checkbox"/>	40. Rejected for employment or insurance for medical reasons <input type="checkbox"/>		<input checked="" type="checkbox"/>
3. Difficulty in vision <input checked="" type="checkbox"/>		23. Rheumatic fever <input type="checkbox"/>	41. Awarded benefits for industrial injury/illness <input type="checkbox"/>		<input checked="" type="checkbox"/>
4. Any ear discharge <input checked="" type="checkbox"/>		24. Abnormal heartbeat <input type="checkbox"/>	42. Treated for a mental condition, e.g. depression <input type="checkbox"/>		<input checked="" type="checkbox"/>
5. Asthma/bronchitis <input checked="" type="checkbox"/>		25. High blood pressure <input type="checkbox"/>	43. Treated for problem drinking or drug abuse <input type="checkbox"/>		<input checked="" type="checkbox"/>
6. Hayfever /other significant allergy <input checked="" type="checkbox"/>		26. Stroke <input type="checkbox"/>	44. Exposed to toxic substance or noise <input type="checkbox"/>		<input checked="" type="checkbox"/>
7. Any skin trouble <input checked="" type="checkbox"/>		27. Serious chest pain <input type="checkbox"/>	FOR WOMEN ONLY		<input type="checkbox"/>
8. Tuberculosis <input checked="" type="checkbox"/>		28. Any blood disease <input type="checkbox"/>	Have you ever had:-		<input type="checkbox"/>
9. Shortness of breath <input checked="" type="checkbox"/>		29. Kidney disease <input type="checkbox"/>	45. An abnormal smear <input type="checkbox"/>		<input type="checkbox"/>
10. Coughed/vomited blood <input checked="" type="checkbox"/>		30. Blood in urine <input type="checkbox"/>	46. Any gynaecological treatment <input type="checkbox"/>		<input type="checkbox"/>
11. Severe abdominal pain <input checked="" type="checkbox"/>		31. Diabetes <input type="checkbox"/>	47. Are you pregnant? <input type="checkbox"/>		<input type="checkbox"/>
12. Stomach ulcer <input checked="" type="checkbox"/>		32. Headaches/migraine <input type="checkbox"/>	48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE <input type="checkbox"/>		<input type="checkbox"/>
13. Recurrent indigestion <input checked="" type="checkbox"/>		33. Dizziness/fainting <input type="checkbox"/>			<input type="checkbox"/>
14. Jaundice or hepatitis <input checked="" type="checkbox"/>		34. Epilepsy <input type="checkbox"/>			<input type="checkbox"/>
15. Gall Bladder disease <input checked="" type="checkbox"/>		35. Joints/spinal trouble <input type="checkbox"/>			<input type="checkbox"/>
16. Marked change in bowel habits <input checked="" type="checkbox"/>		36. Surgical operation <input type="checkbox"/>			<input type="checkbox"/>
17. Blood in stools (motions) <input checked="" type="checkbox"/>		37. Serious accident/fracture <input type="checkbox"/>			<input type="checkbox"/>
18. Marked change in weight <input checked="" type="checkbox"/>		38. Tropical disease <input type="checkbox"/>			<input type="checkbox"/>
19. Varicose veins <input checked="" type="checkbox"/>		39. Fear of heights <input type="checkbox"/>			<input type="checkbox"/>
20. Lump in breast/armpit <input checked="" type="checkbox"/>					<input type="checkbox"/>
How much tobacco each day? <i>✓ (None)</i>		Average daily alcohol consumption <i>X</i>			
Have you ever taken elicited drugs? <i>X</i> 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: <i>18-07-22</i>	Signature of Applicant: <i>[Signature]</i>				





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	BMI	B.P. 140 90.	PULSE 112/mins.	HEARING L (R) R (L)	VISION Uncorrected Corrected	DISTANT R L	NEAR R L	Colour Vision	Blood Group
168	84	29.76							38	

N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A	
		1. Urinalysis			7. Audiogram
		2. Hb, Bloodcount, 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 RESTRICTION TEMPORARY UNFIT UNFIT

Date: 23/07/2023 Name (Block Capitals): Dr. / Nurse

DR. NISANTH KALLINKEEL
Specialist - Internal Medicine
MOH Lic. No: 16847



Signature:

REVIEW/CONSULTATION

Internal Medicine.

Date:

Name (Block Capitals): Dr. / Nurse

DR. ASWATHY RAVI
General Practitioner
MOH Lic. No: 20556
Speciality hospital, Al-Hail

Signature:

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23/07/2023 - Renewed
- Started medicine for dyslipidaemia
- Diet and lifestyle modification
- Report lipid profile after 3 months

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

