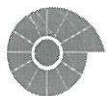



## Appendix 32: EX1 Form (Initial Examination Report)

### INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)



**Petrochem Development Oman  
MEDICAL DEPARTMENT**

PLEASE COMPLETE YOUR PERSONAL  
DETAILS IN BLOCK CAPITALS

Surname <b>AL SULEIMANI</b>	
Forenames <b>HARIB RABIA HARIB</b>	
Address	
Home telephone number	
Place of examination <b>NMC - AL HAIL</b>	Date <b>30/10/2023</b>
If a dependant enter employee's name here:	
Surname:	
Forenames	
Birth date: <b>01/10/1968</b>	Nationality: <b>OMANI</b>
Country of birth:	
Religion:	
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input checked="" 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: <b>8</b>	
Reason for examination	Job: <b>operator</b>
Pre-Employment <input type="checkbox"/>	Pre-Overseas <input type="checkbox"/>
Area: <b>Marmool</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"/>
2. Neck swelling/glands	<input checked="" type="checkbox"/>
3. Difficulty in vision	<input checked="" type="checkbox"/>
4. Any ear discharge	<input checked="" type="checkbox"/>
5. Asthma/bronchitis	<input checked="" type="checkbox"/>
6. Hayfever /other significant allergy	<input checked="" type="checkbox"/>
7. Any skin trouble	<input checked="" type="checkbox"/>
8. Tuberculosis	<input checked="" type="checkbox"/>
9. Shortness of breath	<input checked="" type="checkbox"/>
10. Coughed/vomited blood	<input checked="" type="checkbox"/>
11. Severe abdominal pain	<input checked="" type="checkbox"/>
12. Stomach ulcer	<input checked="" type="checkbox"/>
13. Recurrent indigestion	<input checked="" type="checkbox"/>
14. Jaundice or hepatitis	<input checked="" type="checkbox"/>
15. Gall Bladder disease	<input checked="" type="checkbox"/>
16. Marked change in bowel habits	<input checked="" type="checkbox"/>
17. Blood in stools (motions)	<input checked="" type="checkbox"/>
18. Marked change in weight	<input checked="" type="checkbox"/>
19. Varicose veins	<input checked="" type="checkbox"/>
20. Lump in breast/armpit	<input checked="" type="checkbox"/>
21. Cancer	<input checked="" type="checkbox"/>
22. Heart Disease	<input checked="" type="checkbox"/>
23. Rheumatic fever	<input checked="" type="checkbox"/>
24. Abnormal heart beat	<input checked="" type="checkbox"/>
25. High blood pressure	<input checked="" type="checkbox"/>
26. Stroke	<input checked="" type="checkbox"/>
27. Serious chest pain	<input checked="" type="checkbox"/>
28. Any blood disease	<input checked="" type="checkbox"/>
29. Kidney disease	<input checked="" type="checkbox"/>
30. Blood in urine	<input checked="" type="checkbox"/>
31. Diabetes	<input checked="" type="checkbox"/>
32. Headaches/migraine	<input checked="" type="checkbox"/>
33. Dizziness/fainting	<input checked="" type="checkbox"/>
34. Epilepsy	<input checked="" type="checkbox"/>
35. Joints/spinal trouble	<input checked="" type="checkbox"/>
36. Surgical operation	<input checked="" type="checkbox"/>
37. Serious accident/fracture	<input checked="" type="checkbox"/>
38. Tropical disease	<input checked="" type="checkbox"/>
39. Fear of heights	<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 checked="" type="checkbox"/>
46. Any gynaecological treatment	<input checked="" type="checkbox"/>
47. Are you pregnant?	<input checked="" type="checkbox"/>
48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE	<input checked="" type="checkbox"/>
How much tobacco each day? <b>0</b>	Average daily alcohol consumption <b>0</b>
Have you ever taken illicit drugs? (X) PDO test all new/potential employees for illicit/recreational drugs	
FAMILY HISTORY: Diabetes (Mother) Tuberculosis (X) Epilepsy (X) Asthma (X) Eczema (X)	
Heart disease (X) High blood pressure (X) Stroke (X) Blood Disease (X) Cancer (X)	
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>30.10.23</b>	Signature of Applicant: 

FCR 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.	PULSE	HEARING	VISION	Colour Vision	Blood Group
162	85	25.66	160 100	88/min.	L ? R <input checked="" type="checkbox"/>	DISTANT Uncorrected Corrected R L 6/6 6/6 NEAR R L <input checked="" type="checkbox"/> <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	

N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A	
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	1. Urinalysis Sugar +	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	7. Audiogram
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	2. Hb, Bloodcount, ESR	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	8. Lung Function
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	3. LFT, RFT, RBS	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	9. Chest X-Ray
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	4. Drug Screen	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	10. ECG
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	5. Lipids (40 years +)			11. CVS risk for 40 yrs. & above
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	6. Sickle Cell test			12. HIV, Hepatitis screening

OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc)

FIT

## ASSESSMENT

☒ FIT ALL AREAS ☐ FIT WITH RESTRICTION ☐ TEMPORARY UNFITDR. NISANTH KALLINKEEL  
Specialist - Internal Medicine  
MOH Lic. No: 16847  
hmc specialty hospital, Al-Hail

Date: Name (Block Capitals): Dr / Nurse

Signature:

## REVIEW/CONSULTATION

Uncontrolled T2DM, Sys. HTN - advised Internist consultation

Date: Name (Block Capitals): Dr / Nurse

Signature:

05/11/2023 - Reviewed

- HbA1c 12.9%. Diabetic medication changed.

- Started medication for HTN

- Need to be under regular follow up