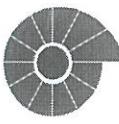
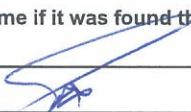


1.1 Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

 <p>Petroleum Development Oman MEDICAL DEPARTMENT</p> <p>PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS</p>		Surname SAID RASHID KHANIS Forenames AL SAADI Address Home telephone number Employment No #																																																																																																																																																		
Place of examination AMC AI - MAIL	Date:- 18/08/2021																																																																																																																																																			
If a dependant enter employee's name here: Surname: <input type="text"/> Forenames: <input type="text"/> Birth date: 11/01/1967 Nationality: OMANI Country of birth: <input type="text"/> Religion: <input type="text"/>																																																																																																																																																				
<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																																																																																																																																																		
Reason for examination Pre-Employment <input type="checkbox"/> Job: <input type="checkbox"/> Pre-Overseas <input type="checkbox"/> Area: <input type="checkbox"/>																																																																																																																																																				
Name and address of family doctor <input type="text"/> (1) (2)		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.)																																																																																																																																																				
<table border="1"> <thead> <tr> <th></th> <th>Y</th> <th>N</th> <th></th> <th>Y</th> <th>N</th> <th></th> </tr> </thead> <tbody> <tr><td>1. Sinus trouble</td><td>/</td><td></td><td>21. Cancer</td><td>/</td><td></td><td>HAVE YOU EVER BEEN:-</td></tr> <tr><td>2. Neck swelling/glands</td><td>/</td><td></td><td>22. Heart Disease</td><td>/</td><td></td><td>40. Rejected for employment or insurance for medical reasons <input checked="" type="checkbox"/></td></tr> <tr><td>3. Difficulty in vision</td><td>/</td><td></td><td>23. Rheumatic fever</td><td>/</td><td></td><td>41. Awarded benefits for industrial injury/illness <input checked="" type="checkbox"/></td></tr> <tr><td>4. Any ear discharge</td><td>/</td><td></td><td>24. Abnormal heartbeat</td><td>/</td><td></td><td>42. Treated for a mental condition, e.g. depression <input checked="" type="checkbox"/></td></tr> <tr><td>5. Asthma/bronchitis</td><td>/</td><td></td><td>25. High blood pressure</td><td>/</td><td></td><td>43. Treated for problem drinking or drug abuse <input checked="" type="checkbox"/></td></tr> <tr><td>6. Hayfever /other significant allergy</td><td>/</td><td></td><td>26. Stroke</td><td>/</td><td></td><td>44. Exposed to toxic substance or noise <input checked="" type="checkbox"/></td></tr> <tr><td>7. Any skin trouble</td><td>/</td><td></td><td>27. Serious chest pain</td><td>/</td><td></td><td></td></tr> <tr><td>8. Tuberculosis</td><td>/</td><td></td><td>28. Any blood disease</td><td>/</td><td></td><td></td></tr> <tr><td>9. Shortness of breath</td><td>/</td><td></td><td>29. Kidney disease</td><td>/</td><td></td><td></td></tr> <tr><td>10. Coughed/vomited blood</td><td>/</td><td></td><td>30. Blood in urine</td><td>/</td><td></td><td></td></tr> <tr><td>11. Severe abdominal pain</td><td>/</td><td></td><td>31. Diabetes</td><td>/</td><td></td><td></td></tr> <tr><td>12. Stomach ulcer</td><td>/</td><td></td><td>32. Headaches/migraine</td><td></td><td></td><td>FOR WOMEN ONLY</td></tr> <tr><td>13. Recurrent indigestion</td><td>/</td><td></td><td>33. Dizziness/fainting</td><td>/</td><td></td><td>Have you ever had:-</td></tr> <tr><td>14. Jaundice or hepatitis</td><td>/</td><td></td><td>34. Epilepsy</td><td>/</td><td></td><td>45. An abnormal smear <input type="checkbox"/></td></tr> <tr><td>15. Gall Bladder disease</td><td>/</td><td></td><td>35. Joints/spinal trouble</td><td>/</td><td></td><td>46. Any gynaecological treatment <input type="checkbox"/></td></tr> <tr><td>16. Marked change in bowel habits</td><td>/</td><td></td><td>36. Surgical operation</td><td>/</td><td></td><td>47. Are you pregnant? <input type="checkbox"/></td></tr> <tr><td>17. Blood in stools (motions)</td><td>/</td><td></td><td>37. Serious accident/fracture</td><td>/</td><td></td><td>48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE <input type="checkbox"/></td></tr> <tr><td>18. Marked change in weight</td><td>/</td><td></td><td>38. Tropical disease</td><td>/</td><td></td><td></td></tr> <tr><td>19. Varicose veins</td><td>/</td><td></td><td>39. Fear of heights</td><td>/</td><td></td><td></td></tr> <tr><td>20. Lump in breast/armpit</td><td>/</td><td></td><td></td><td></td><td></td><td></td></tr> </tbody> </table>			Y	N		Y	N		1. Sinus trouble	/		21. Cancer	/		HAVE YOU EVER BEEN:-	2. Neck swelling/glands	/		22. Heart Disease	/		40. Rejected for employment or insurance for medical reasons <input checked="" type="checkbox"/>	3. Difficulty in vision	/		23. Rheumatic fever	/		41. Awarded benefits for industrial injury/illness <input checked="" type="checkbox"/>	4. Any ear discharge	/		24. Abnormal heartbeat	/		42. Treated for a mental condition, e.g. depression <input checked="" type="checkbox"/>	5. Asthma/bronchitis	/		25. High blood pressure	/		43. Treated for problem drinking or drug abuse <input checked="" type="checkbox"/>	6. Hayfever /other significant allergy	/		26. Stroke	/		44. Exposed to toxic substance or noise <input checked="" type="checkbox"/>	7. Any skin trouble	/		27. Serious chest pain	/			8. Tuberculosis	/		28. Any blood disease	/			9. Shortness of breath	/		29. Kidney disease	/			10. Coughed/vomited blood	/		30. Blood in urine	/			11. Severe abdominal pain	/		31. Diabetes	/			12. Stomach ulcer	/		32. Headaches/migraine			FOR WOMEN ONLY	13. Recurrent indigestion	/		33. Dizziness/fainting	/		Have you ever had:-	14. Jaundice or hepatitis	/		34. Epilepsy	/		45. An abnormal smear <input type="checkbox"/>	15. Gall Bladder disease	/		35. Joints/spinal trouble	/		46. Any gynaecological treatment <input type="checkbox"/>	16. Marked change in bowel habits	/		36. Surgical operation	/		47. Are you pregnant? <input type="checkbox"/>	17. Blood in stools (motions)	/		37. Serious accident/fracture	/		48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE <input type="checkbox"/>	18. Marked change in weight	/		38. Tropical disease	/			19. Varicose veins	/		39. Fear of heights	/			20. Lump in breast/armpit	/					
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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: 18/08/2021		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				only aid Traditional & car driving								
<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	BM	B.P.	PULSE 57/mins.	HEARING L R	VISION			Colour Vision	Blood Group			
178	102		140 82			Uncorrected Corrected	DISTANT R L	NEAR R L					
N	A				LABORATORY AND OTHER SPECIAL INVESTIGATIONS			N	A				
<input checked="" type="checkbox"/> 1. Urinalysis <input checked="" type="checkbox"/> 2. Hb, Blood count, ESR <input checked="" type="checkbox"/> 3. LFT, RFT, RBS <input checked="" type="checkbox"/> 4. Drug Screen <input checked="" type="checkbox"/> 5. Lipids (40 years +) <input checked="" type="checkbox"/> 6. Sickle Cell test							<input checked="" type="checkbox"/> 7. Audiogram <input checked="" type="checkbox"/> 8. Lung Function <input checked="" type="checkbox"/> 9. Chest X-Ray <input checked="" type="checkbox"/> 10. ECG <input checked="" type="checkbox"/> 11. CVS risk for 40 yrs. & above <input checked="" type="checkbox"/> 12. HIV, Hepatitis screening						
OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)													
High BP + High Cholesterol → Needs clinical evaluation to start Rx.													
ASSESSMENT:													
<input checked="" type="checkbox"/> FIT ALL AREAS <input type="checkbox"/> FIT WITH SPECIFIC RESTRICTION <input type="checkbox"/> TEMPORARY UNFIT <input type="checkbox"/> AWAITING SPECIALIST ASSESSMENT													
REVIEW/CONSULTATION													
DATE: 24/8/21	DOCTOR NAME: Dr. Mawad			SIGNATURE: Mawad									

