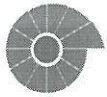



Appendix 32: EX1 Form (Initial Examination Report)

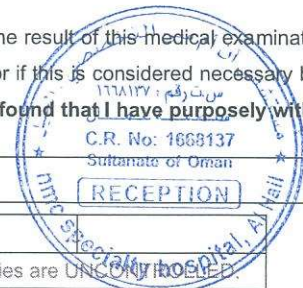
INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)



**Petrochem Development Oman
MEDICAL DEPARTMENT**

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Surname AL HINAI		Forenames KHALFAN MASOUD SAID	
Address		Home telephone number 91735127	
Place of examination NMC HAIL	Date 3/6/2023		
If a dependant enter employee's name here:			
Surname AL HINAI		Forenames KHALFAN MASOUD SAID	
Birth date: 01/01/1972	Nationality: OMANI	Country of birth: OMAN	Religion: MUSLIM
<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	
Reason for examination Pre-Employment <input type="checkbox"/> Pre-Overseas <input type="checkbox"/>		Job: Supervisor Area:	
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	
1. Sinus trouble	<input checked="" type="checkbox"/>	21. Cancer	<input checked="" type="checkbox"/>
2. Neck swelling/glands	<input checked="" type="checkbox"/>	22. Heart Disease	<input checked="" type="checkbox"/>
3. Difficulty in vision	<input checked="" type="checkbox"/>	23. Rheumatic fever	<input checked="" type="checkbox"/>
4. Any ear discharge	<input checked="" type="checkbox"/>	24. Abnormal heartbeat	<input checked="" type="checkbox"/>
5. Asthma/bronchitis	<input checked="" type="checkbox"/>	25. High blood pressure	<input checked="" type="checkbox"/>
6. Hayfever /other significant allergy	<input checked="" type="checkbox"/>	26. Stroke	<input checked="" type="checkbox"/>
7. Any skin trouble	<input checked="" type="checkbox"/>	27. Serious chest pain	<input checked="" type="checkbox"/>
8. Tuberculosis	<input checked="" type="checkbox"/>	28. Any blood disease	<input checked="" type="checkbox"/>
9. Shortness of breath	<input checked="" type="checkbox"/>	29. Kidney disease	<input checked="" type="checkbox"/>
10. Coughed/vomited blood	<input checked="" type="checkbox"/>	30. Blood in urine	<input checked="" type="checkbox"/>
11. Severe abdominal pain	<input checked="" type="checkbox"/>	31. Diabetes	<input checked="" type="checkbox"/>
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/arnpit	<input checked="" type="checkbox"/>		
How much tobacco each day? X		Average daily alcohol consumption X	
I have you ever taken elicited drugs? (X) PDO test all new/potential employees for elicited/recreational drugs			
FAMILY HISTORY: Diabetes (✓) Tuberculosis (X) Epilepsy (X) Asthma (X) Eczema (X) Heart disease (X) High blood pressure (✓) 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: 03-06-2023		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	B/L (6/6 Uncorrected)
<input checked="" type="checkbox"/>		2. E.N.T.	NAD
<input checked="" type="checkbox"/>		3. Teeth & Mouth	NAD
<input checked="" type="checkbox"/>		4. Lungs & Chest	B/L chest is clear.
<input checked="" type="checkbox"/>		5. Cardiovascular System	S1, S2 +0.
<input checked="" type="checkbox"/>		6. Abdo. Viscera	NAD
<input checked="" type="checkbox"/>		7. Hernial Orifices	NAD
<input checked="" type="checkbox"/>		8. Anus & Rectum	NAD
<input checked="" type="checkbox"/>		9. Genito-urinary	NAD
<input checked="" type="checkbox"/>		10. Extremities	NAD
<input checked="" type="checkbox"/>		11. Musculo-skeletal	NAD
<input checked="" type="checkbox"/>		12. Skin & Varicose Vns.	NAD
<input checked="" type="checkbox"/>		13. C.N.S.	Intact.

HEIGHT cm	WEIGHT kg	BMI	B.P.	PULSE	HEARING L N R N	VISION DISTANT R L NEAR R L Uncorrected Corrected	Colour Vision	Blood Group
164	80	31.9	130/90	60 /mins.		6/6 6/6	NAD	-

N	A		LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A	
<input checked="" type="checkbox"/>		1. Urinalysis	↑ FBS - 9.39.	<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. Sickie Cell test		<input checked="" type="checkbox"/>		12. HIV, Hepatitis screening

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

FIT

ASSESSMENT:

☒ FIT ALL AREAS ☐ FIT WITH RESTRICTION ☐ TEMPORARY UNFIT ☐ UNFIT

Date: Name (Block Capitals): Dr. / Nurse

Signature:

REVIEW/CONSULTATION

Recheck FBS, HBA1C - if elevated glucose level found
advised internal consultation for Diabetes control

Date: Name (Block Capitals): Dr. / Nurse

Signature:

