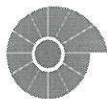




Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

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

Surname		AL YAAQUBI	
Forenames		MARHOUN SALEH HARIB	
Address			
Home telephone number		92565282	
Place of examination	MC - Hail	Date	18/07/2023
If a dependant enter employee's name here:			
Surname: AL YAAQUBI		Forenames: MARHOUN SALEH HARIB	
Birth date: 01/01/1998	Nationality: Omani	Country of birth: Oman	Religion: Islam
<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: 8
Reason for examination		Pre-Employment <input type="checkbox"/> Job: DRIVER	Pre-Overseas <input type="checkbox"/> 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/areola	<input checked="" type="checkbox"/>		
How much tobacco each day? Stopped since 2 years		Average daily alcohol consumption X	
Have you ever taken elicited drugs? (X) PDO test all new/potential employees for elicited/recreational drugs			
FAMILY HISTORY: Diabetes (X) Tuberculosis () Epilepsy () Asthma () Eczema () mother, Heart disease () High blood pressure () Stroke () Blood Disease () Cancer ()			
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: 18.07.23	Signature of Applicant: [Signature]		



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		→ poor oral hygiene			
		4. Lungs & Chest					
		5. Cardiovascular System					
		6. Abdo. Viscera					
		7. Hernial Orifices					
		8. Anus & Rectum		WNL			
		9. Genito-urinary					
		10. Extremities					
		11. Musculo-skeletal					
		12. Skin & Varicose Vns.					
		13. C.N.S.					

HEIGHT cm	WEIGHT kg	BMI	B.P. ?	PULSE	HEARING L R	VISION DISTANT NEAR R L R L	Colour Vision	Blood Group
178	85.2	27.65	164/96	90/min.	L (N) R (N)	Uncorrected: 6/9 6/9 Corrected: 6/6 6/6	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

FIT

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

Signature:

REVIEW/CONSULTATION

23/07/2023

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

Signature:

