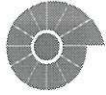




Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

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

Surname SUIDAN AL DARII		Forenames SULTAN MOHAMMED		
Address		Home telephone number 99338944		
Place of examination NMC HAIL	Date 18/6/23			
If a dependant enter employee's name here: Surname: SUIDAN AL DARII Forenames: SULTAN MOHAMMED				
Birth date: 01/01/1971	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	Number of children: 9	
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/armpit		<input checked="" type="checkbox"/>		
How much tobacco each day? NO		Average daily alcohol consumption NO		
Have you ever taken elicited drugs? <input checked="" type="checkbox"/> 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: 18/06/2023		Signature of Applicant: Sultan		





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	B/L vision is (6/6, Uncorrected)
✓		2. E.N.T.	NAD
✓		3. Teeth & Mouth	NAD
✓		4. Lungs & Chest	B/L chest is clear.
✓		5. Cardiovascular System	S ₁ + S ₂ + D.
✓		6. Abdo. Viscera	NAD
✓		7. Hernial Orifices	NAD
✓		8. Anus & Rectum	NAD
✓		9. Genito-urinary	NAD
✓		10. Extremities	NAD
✓		11. Musculo-skeletal	NAD
✓		12. Skin & Varicose Vns.	NAD
✓		13. C.N.S.	Infant.

HEIGHT cm	WEIGHT kg	BMI	B.P.	PULSE	HEARING	VISION	Colour Vision	Blood Group
175	87	28.41	110/71	60/min.	L N R N	DISTANT R L Uncorrected 6/6 Corrected 6/6	NEAR R L N/A	Normal

N	A		LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A	
✓	✓	1. Urinalysis	Blood-Trace in urine	✓		7. Audiogram
✓		2. Hb, Blood count, ESR		✓		8. Lung Function
✓		3. LFT, RFT, RBS				9. Chest X Ray
✓		4. Drug Screen		✓		10. ECG
	✓	5. Lipids (40 years +)	mildly ↑d LDL			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: Name (Block Capitals): Dr. / Nurse

Signature:

REVIEW/CONSULTATION

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

Signature:

DR. ASWATHY RAVI
General Practitioner
MOH Lic. No: 20556
nmc speciality hospital, Al Hail

