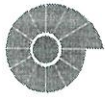




Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

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

Place of examination		Date		Surname AL HINA	
If a dependant enter employee's name here:		Forenames: SALIM MOHAMMED SALMAN		Address	
Home telephone number					
Birth date:		Nationality:		Country of birth:	
Religion:					
<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		Number of children:	
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) Driver (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?			Average daily alcohol consumption		
Have you ever taken elicited drugs? () PDO test all new/potential employees for elicited/recreational drugs No					
FAMILY HISTORY: Diabetes () Tuberculosis () Epilepsy () Asthma () Eczema () 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:		Signature of Applicant:			



FOR COMPLETION BY EXAMINING DOCTOR OR NURSE	
Further details of medical history and recreational activities	
On Rx for dyslipidemia w/ ↑ BP. - T. Valsartan 80 - T. Atorva 10mg.	
N = Normal A = Abnormal (please describe) PHYSICAL EXAMINATION	
N	A
	1. Eyes & Pupils
	2. E.N.T.
	3. Teeth & Mouth
	4. Lungs & Chest
	5. Cardiovascular System
	6. Abdo. Viscera
	7. Hernial Orifices
	8. Anus & Rectum
	9. Genito-urinary
	10. Extremities
	11. Musculo-skeletal
	12. Skin & Varicose Vns.
	13. C.N.S.
HEIGHT cm	WEIGHT kg
164.	100
BMI	B.P.
37.18	163/97 mins.
	93/129/85
PULSE	HEARING
	L
	R
VISION	COLOUR VISION
DISTANT	NEAR
R/L	R/L
Uncorrected	Corrected
6/6	20/20
6/6	20/20
	N.
N	A
	LABORATORY AND OTHER SPECIAL INVESTIGATIONS
	1. Urinalysis
	2. Hb Bloodcount, ESR
	3. LFT, RFT, RBS
	4. Drug Screen
	5. Lipids (40 years +)
	6. Sickie Cell test
	7. Audiogram
	8. Lung Function
	9. Chest X-Ray
	10. ECG
	11. CVS risk for 40 yrs. & above
	12. HIV, Hepatitis screening
OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)	
BMI > 37.18 CUS score > 30% } med cardiologist consultation.	
ASSESSMENT:	
<input checked="" type="checkbox"/> FIT ALL AREAS <input type="checkbox"/> FIT WITH RESTRICTION <input type="checkbox"/> TEMPORARY UNFIT <input type="checkbox"/> UNFIT	
Date:	Name (Block Capitals): Dr. / Nurse
REVIEW/CONSULTATION	
Date:	Name (Block Capitals): Dr. / Nurse
Signature:	