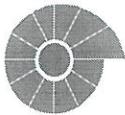


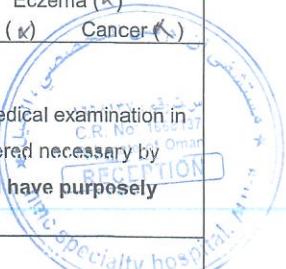
1.1 Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)



Petroleum Development Oman
MEDICAL DEPARTMENT

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Place of examination NMC Al Hail		Date:- 25/11/2021	Surname Khamis Al Mukhaini Forenames Khamis Arouq Barkhit Address																																																							
			Home telephone number																																																							
			Employment No #																																																							
If a dependant enter employee's name here: Surname:		Forenames:																																																								
Birth date: 8/11/1965		Nationality: Oman	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	<input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	Relationship to employee Number of children:																																																						
Reason for examination		Pre-Employment <input type="checkbox"/> Job: 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.)																																																										
<table border="1"> <tr> <th>Y</th> <th>N</th> </tr> <tr> <td><input checked="" type="checkbox"/> 1. Sinus trouble</td> <td><input type="checkbox"/> 21. Cancer</td> </tr> <tr> <td><input checked="" type="checkbox"/> 2. Neck swelling/glands</td> <td><input type="checkbox"/> 22. Heart Disease</td> </tr> <tr> <td><input checked="" type="checkbox"/> 3. Difficulty in vision</td> <td><input type="checkbox"/> 23. Rheumatic fever</td> </tr> <tr> <td><input checked="" type="checkbox"/> 4. Any ear discharge</td> <td><input type="checkbox"/> 24. Abnormal heartbeat</td> </tr> <tr> <td><input checked="" type="checkbox"/> 5. Asthma/bronchitis</td> <td><input type="checkbox"/> 25. High blood pressure</td> </tr> <tr> <td><input checked="" type="checkbox"/> 6. Hayfever /other significant allergy</td> <td><input type="checkbox"/> 26. Stroke</td> </tr> <tr> <td><input checked="" type="checkbox"/> 7. Any skin trouble</td> <td><input type="checkbox"/> 27. 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Epilepsy</td> </tr> <tr> <td><input checked="" type="checkbox"/> 15. Gall Bladder disease</td> <td><input type="checkbox"/> 35. Joints/spinal trouble</td> </tr> <tr> <td><input checked="" type="checkbox"/> 16. Marked change in bowel habits</td> <td><input type="checkbox"/> 36. Surgical operation</td> </tr> <tr> <td><input checked="" type="checkbox"/> 17. Blood in stools (motions)</td> <td><input type="checkbox"/> 37. Serious accident/fracture</td> </tr> <tr> <td><input checked="" type="checkbox"/> 18. Marked change in weight</td> <td><input type="checkbox"/> 38. Tropical disease</td> </tr> <tr> <td><input checked="" type="checkbox"/> 19. Varicose veins</td> <td><input type="checkbox"/> 39. Fear of heights</td> </tr> <tr> <td><input checked="" type="checkbox"/> 20. Lump in breast/armpit</td> <td></td> </tr> </table>		Y	N	<input checked="" type="checkbox"/> 1. Sinus trouble	<input type="checkbox"/> 21. Cancer	<input checked="" type="checkbox"/> 2. 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FOR WOMEN ONLY 45. An abnormal smear 46. Any gynaecological treatment 47. Are you pregnant? 48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE																																																										
How much tobacco each day? Yes - 20 Cig. per day Average daily alcohol consumption No																																																										
Have you ever taken elicited drugs? () PDO test all new/potential employees for elicited/recreational drugs																																																										
FAMILY HISTORY: Diabetes (<input checked="" type="checkbox"/>) Tuberculosis (<input checked="" type="checkbox"/>) Epilepsy (<input type="checkbox"/>) Asthma (<input checked="" type="checkbox"/>) Eczema (<input type="checkbox"/>) Heart disease (<input checked="" type="checkbox"/>) High blood pressure (<input checked="" type="checkbox"/>) Mother Stroke (<input checked="" type="checkbox"/>) Blood Disease (<input type="checkbox"/>) Cancer (<input 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: 25/11/2021		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												
	✓ 1. Eyes & Pupils	doctor's vision in L eye worse than R eye (sharp decrease).											
✓	2. E.N.T.												
✓	3. Teeth & Mouth												
✓	4. Lungs & Chest												
✓	5. Cardiovascular System	5 year from previous knee surgery (L knee) on 1991											
✓	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	BM I	B.P. 112 68	PULSE 64/mins.	HEARING L R	VISION DISTANT R L NEAR R L					Colour Vision	Blood Group	
165cm	98kg	36.				Uncorrected Corrected	wearing eye glasses.						
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS											
✓	1. Urinalysis	✓ 7. Audiogram											
✓	2. Hb, Blood count, ESR → High.	✓ 8. Lung Function											
✓	3. LFT, RFT, RBS	✓ 9. Chest X-Ray											
✓	4. Drug Screen	✓ 10. ECG											
✓	5. Lipids (40 years +) → ↑ 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.)

Foramingham Risk Score = 9.4% (Low Risk).

ASSESSMENT:

- FIT ALL AREAS
- FIT WITH SPECIFIC RESTRICTION
- TEMPORARY UNFIT
- AWAITING SPECIALIST ASSESSMENT

REVIEW/CONSULTATION

DATE: 11/12/21

DOCTOR NAME:

Dr. Majeed

SIGNATURE:

DR. Majeed
General Practitioner
MOH Lic No. 11004
nmc specialty hospital Al-Hail

