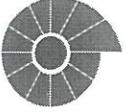


1.1 Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

 <p>Petroleum Development Oman MEDICAL DEPARTMENT</p> <p>PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS</p>		Surname <u>AL BALUSHI</u> Forenames <u>IBRAHIM NAJ BAKHT CHAR</u> Address Home telephone number Employment No #																																																																																																																																																																																															
Place of examination <u>MNC AL HAIL</u>	Date:- <u>08-07-2021</u>																																																																																																																																																																																																
If a dependant enter employee's name here:																																																																																																																																																																																																	
Surname:	Forenames:																																																																																																																																																																																																
Birth date: <u>01-01-1970</u>	Nationality: <u>QATAR</u>	Country of birth:	Religion:																																																																																																																																																																																														
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married <input checked="" 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 checked="" type="checkbox"/>	Job: <u>Worker.</u>	Number of children:																																																																																																																																																																																														
	Pre-Overseas <input type="checkbox"/>	Area:																																																																																																																																																																																															
Name and address of family doctor <u>Mohamed A. moustafa.</u>	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"> <thead> <tr> <th></th> <th>Y</th> <th>N</th> <th></th> <th>Y</th> <th>N</th> <th></th> <th>Y</th> <th>N</th> </tr> </thead> <tbody> <tr><td>1. Sinus trouble</td><td></td><td></td><td>21. Cancer</td><td></td><td></td><td>HAVE YOU EVER BEEN:-</td><td></td><td></td></tr> <tr><td>2. Neck swelling/glands</td><td></td><td></td><td>22. Heart Disease</td><td></td><td></td><td>40. Rejected for employment or insurance for medical reasons</td><td></td><td></td></tr> <tr><td>3. Difficulty in vision</td><td></td><td></td><td>23. Rheumatic fever</td><td></td><td></td><td>41. Awarded benefits for industrial injury/illness</td><td></td><td></td></tr> <tr><td>4. Any ear discharge</td><td></td><td></td><td>24. Abnormal heartbeat</td><td></td><td></td><td>42. Treated for a mental condition, e.g. depression</td><td></td><td></td></tr> <tr><td>5. Asthma/bronchitis</td><td></td><td></td><td>25. High blood pressure</td><td></td><td></td><td>43. Treated for problem drinking or drug abuse</td><td></td><td></td></tr> <tr><td>6. Hayfever /other significant allergy</td><td></td><td></td><td>26. Stroke</td><td></td><td></td><td>44. Exposed to toxic substance or noise</td><td></td><td></td></tr> <tr><td>7. Any skin trouble</td><td></td><td></td><td>27. Serious chest pain</td><td></td><td></td><td>FOR WOMEN ONLY</td><td></td><td></td></tr> <tr><td>8. Tuberculosis</td><td></td><td></td><td>28. Any blood disease</td><td></td><td></td><td>Have you ever had:-</td><td></td><td></td></tr> <tr><td>9. Shortness of breath</td><td></td><td></td><td>29. Kidney disease</td><td></td><td></td><td>45. An abnormal smear</td><td></td><td></td></tr> <tr><td>10. Coughed/vomited blood</td><td></td><td></td><td>30. Blood in urine</td><td></td><td></td><td>46. Any gynaecological treatment</td><td></td><td></td></tr> <tr><td>11. Severe abdominal pain</td><td></td><td></td><td>31. Diabetes</td><td></td><td></td><td>47. Are you pregnant?</td><td></td><td></td></tr> <tr><td>12. Stomach ulcer</td><td></td><td></td><td>32. Headaches/migraine</td><td></td><td></td><td>48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE</td><td></td><td></td></tr> <tr><td>13. Recurrent indigestion</td><td></td><td></td><td>33. Dizziness/fainting</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>14. Jaundice or hepatitis</td><td></td><td></td><td>34. Epilepsy</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>15. Gall Bladder disease</td><td></td><td></td><td>35. Joints/spinal trouble</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>16. Marked change in bowel habits</td><td></td><td></td><td>36. Surgical operation</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>17. Blood in stools (motions)</td><td></td><td></td><td>37. Serious accident/fracture</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>18. Marked change in weight</td><td></td><td></td><td>38. Tropical disease</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>19. Varicose veins</td><td></td><td></td><td>39. Fear of heights</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>20. Lump in breast/armpit</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> </tbody> </table>			Y	N		Y	N		Y	N	1. Sinus trouble			21. Cancer			HAVE YOU EVER BEEN:-			2. Neck swelling/glands			22. Heart Disease			40. Rejected for employment or insurance for medical reasons			3. Difficulty in vision			23. Rheumatic fever			41. Awarded benefits for industrial injury/illness			4. Any ear discharge			24. Abnormal heartbeat			42. Treated for a mental condition, e.g. depression			5. Asthma/bronchitis			25. High blood pressure			43. Treated for problem drinking or drug abuse			6. Hayfever /other significant allergy			26. Stroke			44. Exposed to toxic substance or noise			7. Any skin trouble			27. Serious chest pain			FOR WOMEN ONLY			8. Tuberculosis			28. Any blood disease			Have you ever had:-			9. Shortness of breath			29. Kidney disease			45. An abnormal smear			10. Coughed/vomited blood			30. Blood in urine			46. Any gynaecological treatment			11. Severe abdominal pain			31. Diabetes			47. Are you pregnant?			12. Stomach ulcer			32. Headaches/migraine			48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE			13. Recurrent indigestion			33. Dizziness/fainting						14. Jaundice or hepatitis			34. Epilepsy						15. Gall Bladder disease			35. Joints/spinal trouble						16. Marked change in bowel habits			36. Surgical operation						17. Blood in stools (motions)			37. Serious accident/fracture						18. Marked change in weight			38. Tropical disease						19. Varicose veins			39. Fear of heights						20. Lump in breast/armpit											
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Have you ever taken elicited drugs? <u>NO</u> PDO test all new/potential employees for elicited/recreational drugs																																																																																																																																																																																																	
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PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT:- <p>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.</p>																																																																																																																																																																																																	
Date: <u>07/07/2021</u>		Signature of Applicant: <u>8-7-2021</u>																																																																																																																																																																																															

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		NAD							
		2. E.N.T.		NAD							
		3. Teeth & Mouth		NAD							
		4. Lungs & Chest		NAD							
		5. Cardiovascular System		NAD							
		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.		NAD							
HEIGHT cm	WEIGHT kg	BM I	B.P. 121 82	PULSE /mins. 90	HEARING L R	VISION DISTANT Uncorrected Corrected	NEAR R L N N	Colour Vision	Blood Group		
160	55							N	—		
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS				N	A				
		1. Urinalysis						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 +)						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.)

W 0

ASSESSMENT:

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

REVIEW/CONSULTATION

8-7-2021 Mohamed Ahmed
Moustafa

DATE:

DOCTOR NAME:

Mohamed A.
Moustafa

SIGNATURE: