



## Appendix 32: EX1 Form (Initial Examination Report)

## INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

<b>Petroleum Development Oman MEDICAL DEPARTMENT</b> PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS		Surname <b>AL BALKISHI</b> Forenames <b>KHAMIS SAD MUBARAK MASOOD</b> Address Home telephone number																																																																							
Place of examination <b>NMC AL MALL</b>   Date <b>13/04/23</b>																																																																									
If a dependant enter employee's name here: Surname: _____ Forenames: _____ Birth date: <b>11/03/1983</b> Nationality: <b>OMAN</b> 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"/> Pre-Overseas <input type="checkbox"/>		Job: Area:		<i>Periodical checkup @ age 50</i>																																																																					
Name and address of family doctor		List your last 3 obs (1) <b>Manual labourer for machine transportation</b> (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.)																																																																									
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How much tobacco each day? <b>No</b>		Average daily alcohol consumption																																																																							
Have you ever taken elicited drugs? ( ) PDO test all new/potential employees for elicited/recreational drugs																																																																									
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>mother</i> 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 CR NRSE  
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										
		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.				Physical Examination								
HEIGHT cm	WEIGHT kg	BMI	B.P.	PULSE 57 mins.	HEARING L R	VISION Uncorrected Corrected	DISTANT R L	NEAR R L	Colour Vision	Blood Group		
174	71	23.4	130/80									

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

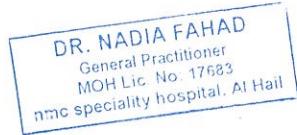
## OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)



ASSESSMENT		
<input type="checkbox"/> FIT ALL AREAS	<input type="checkbox"/> FIT WITH RESTRICTION	<input type="checkbox"/> TEMPORARY UNFIT

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

## REVIEW/CONSULTATION



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

Signature:

Signature: