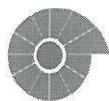



Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)



**Petroleum Development Oman
MEDICAL DEPARTMENT**

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Place of examination NMC SPECIALITY AL HAIL		Date 7 11 23		Home telephone number	
If a dependant enter employee's name here:					
Surname:			Forenames:		
Birth date:		Nationality:		Country of birth:	
Religion:					
<input 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:			
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.)					
		Y N		Y N	
1. Sinus trouble		<input checked="" type="checkbox"/>		21. Cancer	
2. Neck swelling/glands		<input checked="" type="checkbox"/>		22. Heart Disease	
3. Difficulty in vision		<input checked="" type="checkbox"/>		23. Rheumatic fever	
4. Any ear discharge		<input checked="" type="checkbox"/>		24. Abnormal heartbeat	
5. Asthma/bronchitis		<input checked="" type="checkbox"/>		25. High blood pressure	
6. Hayfever /other significant allergy		<input checked="" type="checkbox"/>		26. Stroke	
7. Any skin trouble		<input checked="" type="checkbox"/>		27. Serious chest pain	
8. Tuberculosis		<input checked="" type="checkbox"/>		28. Any blood disease	
9. Shortness of breath		<input checked="" type="checkbox"/>		29. Kidney disease	
10. Coughed/vomited blood		<input checked="" type="checkbox"/>		30. Blood in urine	
11. Severe abdominal pain		<input checked="" type="checkbox"/>		31. Diabetes	
12. Stomach ulcer		<input checked="" type="checkbox"/>		32. Headaches/migraine	
13. Recurrent indigestion		<input checked="" type="checkbox"/>		33. Dizziness/fainting	
14. Jaundice or hepatitis		<input checked="" type="checkbox"/>		34. Epilepsy	
15. Gall Bladder disease		<input checked="" type="checkbox"/>		35. Joints/spinal trouble	
16. Marked change in bowel habits		<input checked="" type="checkbox"/>		36. Surgical operation	
17. Blood in stools (motions)		<input checked="" type="checkbox"/>		37. Serious accident/fracture	
18. Marked change in weight		<input checked="" type="checkbox"/>		38. Tropical disease	
19. Varicose veins		<input checked="" type="checkbox"/>		39. Fear of heights	
20. Lump in breast/armpit		<input checked="" type="checkbox"/>			
HAVE YOU EVER BEEN:-					
40. Rejected for employment or insurance for medical reasons		<input checked="" type="checkbox"/>			
41. Awarded benefits for industrial injury/illness		<input checked="" type="checkbox"/>			
42. Treated for a mental condition, e.g. depression		<input checked="" type="checkbox"/>			
43. Treated for problem drinking or drug abuse		<input checked="" type="checkbox"/>			
44. Exposed to toxic substance or noise		<input checked="" type="checkbox"/>			
FOR WOMEN ONLY					
Have you ever had:-					
45. An abnormal smear		<input type="checkbox"/>			
46. Any gynaecological treatment		<input type="checkbox"/>			
47. Are you pregnant?		<input type="checkbox"/>			
48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE		<input type="checkbox"/>			
How much tobacco each day? NO.					
Average daily alcohol consumption NO.					
Have you ever taken elicited drugs? (X) PDO test all new/potential employees for elicited/recreational drugs					
FAMILY HISTORY:					
Diabetes (X)		Tuberculosis (X)		Epilepsy (X)	
Heart disease (X)		High blood pressure (X)		Stroke (X)	
Asthma (X)		Blood Disease (X)		Cancer (X)	
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

N = Normal A = Abnormal (please describe)				PHYSICAL EXAMINATION									
N	A												
✓	✓	1. Eyes & Pupils		Bsp. Corrected vision is 6/9.									
✓		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		BMI	B.P.	PULSE	HEARING		VISION		Colour Vision	Blood Group	
162		109		41.5	123 67	78 /mins.	L N R ~		DISTANT R L Uncorrected Corrected 6/9 6/9		NEAR R L N N	Normal	
N	A					LABORATORY AND OTHER SPECIAL INVESTIGATIONS				N	A		
✓		1. Urinalysis				9-47. Framingham score				✓		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. Sicko Coll test								✓		12. HIV, Hepatitis screening	

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

• Morbid Obesity.



ASSESSMENT:

☒ FIT ALL AREAS ☐ FIT WITH RESTRICTION ☐ TEMPORARY UNFIT ☐ UNFIT

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

Signature:

REVIEW/CONSULTATION

8/11/23

DR. NADIA FAHAD
General Practitioner
MOH Lic. No: 17683
nmc speciality hospital, Al Hail



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

Signature: