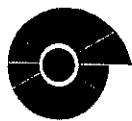


# 1383

(18)

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

## INITIAL EXAMINATION REPORT (MEDICAL - CONFIDENTIAL)

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

Place of examination Adam		Date 29/3/19	Surname Haypal Singh			
			Forenames			
			Address			
			Home telephone number			
			Employment No # 1383			
If a dependant enter employee's name here: Surname: Birth date: 1/1/1984 Nationality: India <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced <input checked="" type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter Number of children: 2						
Reason for examination		Pre-Employment <input type="checkbox"/> Job: Crane Operator	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.)						
1. Sinus trouble <input checked="" type="checkbox"/> 2. Neck swelling/glands <input checked="" type="checkbox"/> 3. Difficulty in vision <input checked="" type="checkbox"/> 4. Any ear discharge <input checked="" type="checkbox"/> 5. Asthma/bronchitis <input checked="" type="checkbox"/> 6. Hayfever /other significant allergy <input checked="" type="checkbox"/> 7. Any skin trouble <input checked="" type="checkbox"/> 8. Tuberculosis <input checked="" type="checkbox"/> 9. Shortness of breath <input checked="" type="checkbox"/> 10. Coughed/vomited blood <input checked="" type="checkbox"/> 11. Severe abdominal pain <input checked="" type="checkbox"/> 12. Stomach ulcer <input checked="" type="checkbox"/> 13. Recurrent indigestion <input checked="" type="checkbox"/> 14. Jaundice or hepatitis <input checked="" type="checkbox"/> 15. Gall Bladder disease <input checked="" type="checkbox"/> 16. Marked change in bowel habits <input checked="" type="checkbox"/> 17. Blood in stools (motions) <input checked="" type="checkbox"/> 18. Marked change in weight <input checked="" type="checkbox"/> 19. Varicose veins <input checked="" type="checkbox"/> 20. Lump in breast/armpit <input checked="" type="checkbox"/>		Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	21. Cancer <input checked="" type="checkbox"/> 22. Heart Disease <input checked="" type="checkbox"/> 23. Rheumatic fever <input checked="" type="checkbox"/> 24. Abnormal heartbeat <input checked="" type="checkbox"/> 25. High blood pressure <input checked="" type="checkbox"/> 26. Stroke <input checked="" type="checkbox"/> 27. Serious chest pain <input checked="" type="checkbox"/> 28. Any blood disease <input checked="" type="checkbox"/> 29. Kidney disease <input checked="" type="checkbox"/> 30. Blood in urine <input checked="" type="checkbox"/> 31. Diabetes <input checked="" type="checkbox"/> 32. Headaches/migraine <input checked="" type="checkbox"/> 33. Dizziness/fainting <input checked="" type="checkbox"/> 34. Epilepsy <input checked="" type="checkbox"/> 35. Joints/spinal trouble <input checked="" type="checkbox"/> 36. Surgical operation <input checked="" type="checkbox"/> 37. Serious accident/fracture <input checked="" type="checkbox"/> 38. Tropical disease <input checked="" type="checkbox"/> 39. Fear of heights <input checked="" type="checkbox"/>	Y <input checked="" type="checkbox"/> N <input 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 checked="" type="checkbox"/>  46. Any gynaecological treatment <input checked="" type="checkbox"/> 47. Are you pregnant? <input checked="" type="checkbox"/>  48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE <input checked="" type="checkbox"/>	
How much tobacco each day? no		Average daily alcohol consumption no				
Have you ever taken elicited drugs? <input checked="" type="checkbox"/> PDO test all new/potential employees for elicited/recreational drugs						
FAMILY HISTORY: Diabetes <input checked="" type="checkbox"/> Tuberculosis <input checked="" type="checkbox"/> Epilepsy <input checked="" type="checkbox"/> Asthma <input checked="" type="checkbox"/> Eczema <input checked="" type="checkbox"/> Heart disease <input checked="" type="checkbox"/> High blood pressure <input checked="" type="checkbox"/> Stroke <input checked="" type="checkbox"/> Blood Disease <input checked="" type="checkbox"/> Cancer <input checked="" 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: 29/3/19		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											
<input checked="" type="checkbox"/>		1. Eyes & Pupils										
<input checked="" type="checkbox"/>		2. E.N.T.										
<input checked="" type="checkbox"/>		3. Teeth & Mouth										
<input checked="" type="checkbox"/>		4. Lungs & Chest										
<input checked="" type="checkbox"/>		5. Cardiovascular System										
<input checked="" type="checkbox"/>		6. Abdo. Viscera										
<input checked="" type="checkbox"/>		7. Hernial Orifices										
<input checked="" type="checkbox"/>		8. Anus & Rectum										
<input checked="" type="checkbox"/>		9. Genito-urinary										
<input checked="" type="checkbox"/>		10. Extremities										
<input checked="" type="checkbox"/>		11. Musculo-skeletal										
<input checked="" type="checkbox"/>		12. Skin & Varicose Vns.										
<input checked="" type="checkbox"/>		13. C.N.S.										
HEIGHT cm		WEIGHT kg	BM I	B.P. 140 90	PULSE 78 mins.	HEARING L R	VISION				Colour Vision	Blood Group
173	103	34					DISTANT R L	NEAR R L				
						Uncorrected Corrected	6/6 6/6	4/6 4/6				
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS						N	A			
										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.)**

## FRAMING ASSESSMENT

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

## **REVIEW/CONSULTATION**

DATE: 02/04/19

**SIGNATURE:**