



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

## INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

Petroleum Development Oman  
MEDICAL DEPARTMENTPLEASE COMPLETE YOUR PERSONAL  
DETAILS IN BLOCK CAPITALSPlace of examination **NMC HALL** Date **13/2/23**

If a dependant enter employee's name here:

Surname **RADHAKRISHNAN**Birth date:  Nationality: **INDIAN** Male  Female Married Single Separated /Divorced Wife  Son  DaughterNumber of  
children: 

Surname <b>RADHAKRISHNAN</b>	
Forenames <b>NAR</b>	
Address <b> </b>	
Home telephone number <b>+971 92348351</b>	

Reason for examination

Pre-Employment

 Job:

Pre-Overseas

 Area:

Name and address of family doctor

List your last 3 jobs

(1)

(2)

Are you a Registered Disabled Person? (UK only)

Do you belong to any Medical Insurance Scheme? 

DO YOU HAVE OR HAVE YOU HAD:- (Tick "Yes" or "No" column or put a (?) if uncertain exclude minor ailments.)

	<b>Y</b>	<b>N</b>		<b>Y</b>	<b>N</b>		<b>Y</b>	<b>N</b>
1. Sinus trouble	<input checked="" type="checkbox"/>	<input type="checkbox"/>	21. Cancer	<input checked="" type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER BEEN:-		
2. Neck swelling/glands	<input checked="" type="checkbox"/>	<input type="checkbox"/>	22. Heart Disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>	40. Rejected for employment or insurance for medical reasons	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Difficulty in vision	<input checked="" type="checkbox"/>	<input type="checkbox"/>	23. Rheumatic fever	<input checked="" type="checkbox"/>	<input type="checkbox"/>	41. Awarded benefits for industrial injury/illness	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Any ear discharge	<input checked="" type="checkbox"/>	<input type="checkbox"/>	24. Abnormal heartbeat	<input checked="" type="checkbox"/>	<input type="checkbox"/>	42. Treated for a mental condition, e.g. depression	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Asthma/bronchitis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	25. High blood pressure	<input checked="" type="checkbox"/>	<input type="checkbox"/>	43. Treated for problem drinking or drug abuse	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Hayfever /other significant allergy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	26. Stroke	<input checked="" type="checkbox"/>	<input type="checkbox"/>	44. Exposed to toxic substance or noise	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Any skin trouble	<input checked="" type="checkbox"/>	<input type="checkbox"/>	27. Serious chest pain	<input checked="" type="checkbox"/>	<input type="checkbox"/>	FOR WOMEN ONLY		
8. Tuberculosis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	28. Any blood disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Have you ever had:-		
9. Shortness of breath	<input checked="" type="checkbox"/>	<input type="checkbox"/>	29. Kidney disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>	45. An abnormal smear	<input checked="" type="checkbox"/>	<input type="checkbox"/>
10. Coughed/vomited blood	<input checked="" type="checkbox"/>	<input type="checkbox"/>	30. Blood in urine	<input checked="" type="checkbox"/>	<input type="checkbox"/>	46. Any gynaecological treatment <i>for haemorrhoids</i>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
11. Severe abdominal pain	<input checked="" type="checkbox"/>	<input type="checkbox"/>	31. Diabetes	<input checked="" type="checkbox"/>	<input type="checkbox"/>	47. Are you pregnant?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
12. Stomach Ulcer	<input checked="" type="checkbox"/>	<input type="checkbox"/>	32. Headaches/migraine	<input checked="" type="checkbox"/>	<input type="checkbox"/>	48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE	<input checked="" type="checkbox"/>	<input type="checkbox"/>
13. Recurrent indigestion	<input checked="" type="checkbox"/>	<input type="checkbox"/>	33. Dizziness/fainting	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
14. Jaundice or hepatitis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	34. Epilepsy	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
15. Gall Bladder disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>	35. Joints/spinal trouble	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
16. Marked change in bowel habits	<input checked="" type="checkbox"/>	<input type="checkbox"/>	36. Surgical operation	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
17. Blood in stools (motions)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	37. Serious accident/fracture	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
18. Marked change in weight	<input checked="" type="checkbox"/>	<input type="checkbox"/>	38. Tropical disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
19. Varicose veins	<input checked="" type="checkbox"/>	<input type="checkbox"/>	39. Fear of heights	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
20. Lump in breast/armpit	<input checked="" type="checkbox"/>	<input type="checkbox"/>						

How much tobacco each day?

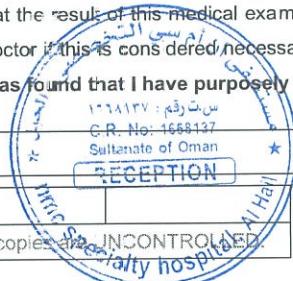
Average daily alcohol consumption

*occasionally*Have you ever taken elicited drugs?  PDO test all new/potential employees for elicited/recreational drugs

<b>FAMILY HISTORY:</b>	Diabetes ( <input checked="" type="checkbox"/> )	Tuberculosis ( <input type="checkbox"/> )	Epilepsy ( <input 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 declare 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: **13/2/23**Signature of Applicant: **a. Radh**



FOR COMPLETION BY EXAMINING DOCTOR OR NURSE  
Further details of medical history and recreational activities

N = Normal A = Abnormal (please describe) PHYSICAL EXAMINATION

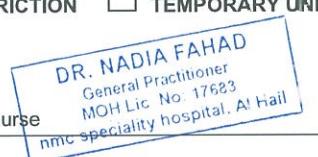
N	A											
✓		1. Eyes & Pupils										
✓		2. E.N.T.										
✓		3. Teeth & Mouth										
✓		4. Lungs & Chest										
✓		5. Cardiovascular System										
✓		6. Abdo. Viscera										
✓		7. Hernial Orifices										
✓		8. Anus & Rectum										
✓		9. Genito-urinary										
✓		10. Extremities										
✓		11. Musculo-skeletal										
✓		12. Skin & Varicose Vns										
✓		13. C.N.S.										

HEIGHT cm	WEIGHT kg	BMI	B.P. mmHg	PULSE b/mins.	HEARING L R	VISION Uncorrected Corrected	DISTANT F L	NEAR R L	Colour Vision	Blood Group
174	65	21.47	124/76	60	L 2 R	6/6 6/6	F L	R L	N	

N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A
✓		1. Urinalysis		7. Audiogram
✓		2. Hb, Bloodcount, ESR		8. Lung Function
✓		3. LFT, RFT, RES		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. H V, Hepatitis screening

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

ASSESSMENT:				
<input checked="" type="checkbox"/> FIT ALL AREAS	<input type="checkbox"/> FIT WITH RESTRICTION	<input type="checkbox"/> TEMPORARY UNFIT	<input type="checkbox"/> UNFIT	
Date: 13/4/23 Name (Block Capitals): Dr. / Nurse				Signature:

REVIEW/CONSULTATION				
				Signature:
				Signature:
Date:	Name (Block Capitals): Dr. / Nurse			