



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 **NMCA HAIL** Date **16/08/22**

Surname SITAL SINGH	
Forenames SATWINDER SINGH	
Address	
Home telephone number 95508297	

If a dependant enter employee's name here:

Surname: SITAL SINGH		Forenames: SATWINDER SINGH	
Birth date: 20/09/1969	Nationality: INDIA	Country of birth: INDIA	Religion: SIKH

<input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	<input checked="" 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	Relationship to employee	Number of children: 2
--	--	---	--------------------------	------------------------------

Reason for examination	Pre-Employment	Job: FOREMAN
	Pre-Overseas	Area:

Name and address of family doctor Dr. Masood Siddique	List your last 3 jobs (1) FOREMAN (2) FOREMAN
--	---

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

I how much tobacco each day?	Average daily alcohol consumption
------------------------------	-----------------------------------

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: 16/08/2022	Signature of Applicant: S. Singh
-------------------------	---





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				PULSE	HEARING	VISION	DISTANT	NEAR	Colour Vision	Blood Group
✓		1. Eyes & Pupils			B/P vision is 6/6 (Corrected)						
✓		2. E.N.T.			N/A						
✓		3. Teeth & Mouth			N/A						
✓		4. Lungs & Chest			B/P chest is clear. S, S, to						
✓		5. Cardiovascular System			NOT palpable.						
✓		6. Abdo. Viscera			N/A						
✓		7. Genital Orifices			N/A						
✓		8. Anus & Rectum			N/A						
✓		9. Genito-urinary			N/A						
✓		10. Extremities			N/A						
✓		11. Musculo-skeletal			N/A						
✓	✓	12. Skin & Varicose Vns.			No Eczema.						
✓		13. C.N.S.			Unfit.						
HEIGHT cm	WEIGHT kg	BMI	B.P.	92 /min.	L N R N	Uncorrected Corrected	R L R L	96/6 N/N	Normal		
191	100.7	27.6	138/95								

N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS			N	A			
✓		1. Urinalysis			✓		7. Audiogram		
✓		2. Hb, Bloodcount, ESR			✓		8. Lung Function		
		3. LFT, RFT, RBS FBS			✓		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.)

* Over weight
* Elevated SP w/o Dx of HTN.

High FBS
Elevated BP
Over weight.
Elevated LDL

ASSESSMENT:

FIT ALL AREAS FIT WITH RESTRICTION TEMPORARY UNFIT UNFIT

Reviewed the patient. Medicines prescribed for high blood sugar. Diet modifications
Need to be under regular follow up

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

Signature:

DR. NISANTH KALLINKEEL
Specialist - Internal Medicine
MOH Lic. No: 16847
nmc specialty hospital, Al-Hail

REVIEW/CONSULTATION

Internal Medicine Consultation

Date: 16/8/22 Name (Block Capitals): Dr. / Nurse

Dr. Malood

