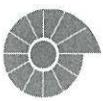




Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

 Petroleum Development Oman MEDICAL DEPARTMENT PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS		Surname DANIEL																																																																																																											
		Forenames BINU																																																																																																											
		Address WIMAR (HANEMA)																																																																																																											
Place of examination		Home telephone number																																																																																																											
If a dependant enter employee's name here:																																																																																																													
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Birth date: INDIAN		Country of birth INDIA Religion: Christian																																																																																																											
<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"/> Job: PDO medical.		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.)																																																																																																													
<table border="1"> <tr> <td><input type="checkbox"/> Y</td> <td><input type="checkbox"/> N</td> </tr> <tr> <td colspan="2">1. Sinus trouble</td> </tr> <tr> <td colspan="2">2. Neck swelling/glands</td> </tr> <tr> <td colspan="2">3. Difficulty in vision</td> </tr> <tr> <td colspan="2">4. Any ear discharge</td> </tr> <tr> <td colspan="2">5. Asthma/bronchitis</td> </tr> <tr> <td colspan="2">6. Hayfever /other significant allergy</td> </tr> <tr> <td colspan="2">7. Any skin trouble</td> </tr> <tr> <td colspan="2">8. Tuberculosis</td> </tr> <tr> <td colspan="2">9. Shortness of breath</td> </tr> <tr> <td colspan="2">10. Coughed/vomited blood</td> </tr> <tr> <td colspan="2">11. Severe abdominal pain</td> </tr> <tr> <td colspan="2">12. Stomach ulcer</td> </tr> <tr> <td colspan="2">13. Recurrent indigestion</td> </tr> <tr> <td colspan="2">14. Jaundice or hepatitis</td> </tr> <tr> <td colspan="2">15. Gall Bladder disease</td> </tr> <tr> <td colspan="2">16. Marked change in bowel habits</td> </tr> <tr> <td colspan="2">17. Blood in stools motions</td> </tr> <tr> <td colspan="2">18. Marked change in weight</td> </tr> <tr> <td colspan="2">19. Varicose veins</td> </tr> <tr> <td colspan="2">20. Lump in breast/armpit</td> </tr> </table>		<input type="checkbox"/> Y	<input type="checkbox"/> N	1. Sinus trouble		2. Neck swelling/glands		3. Difficulty in vision		4. Any ear discharge		5. Asthma/bronchitis		6. Hayfever /other significant allergy		7. Any skin trouble		8. Tuberculosis		9. Shortness of breath		10. Coughed/vomited blood		11. Severe abdominal pain		12. Stomach ulcer		13. Recurrent indigestion		14. Jaundice or hepatitis		15. Gall Bladder disease		16. Marked change in bowel habits		17. Blood in stools motions		18. Marked change in weight		19. Varicose veins		20. Lump in breast/armpit		<table border="1"> <tr> <td><input type="checkbox"/> Y</td> <td><input type="checkbox"/> N</td> </tr> <tr> <td colspan="2">21. Cancer</td> </tr> <tr> <td colspan="2">22. Heart Disease</td> </tr> <tr> <td colspan="2">23. Rheumatic fever</td> </tr> <tr> <td colspan="2">24. Abnormal heartbeat</td> </tr> <tr> <td colspan="2">25. High blood pressure</td> </tr> <tr> <td colspan="2">26. Stroke</td> </tr> <tr> <td colspan="2">27. Serious chest pain</td> </tr> <tr> <td colspan="2">28. Any blood disease</td> </tr> <tr> <td colspan="2">29. Kidney disease</td> </tr> <tr> <td colspan="2">30. Blood in urine</td> </tr> <tr> <td colspan="2">31. Diabetes</td> </tr> <tr> <td colspan="2">32. Headaches/migraine</td> </tr> <tr> <td colspan="2">33. Dizziness/fainting</td> </tr> <tr> <td colspan="2">34. Epilepsy</td> </tr> <tr> <td colspan="2">35. Joints/spinal trouble</td> </tr> <tr> <td colspan="2">36. Surgical operation</td> </tr> <tr> <td colspan="2">37. Serious accident/fracture</td> </tr> <tr> <td colspan="2">38. Tropical disease</td> </tr> <tr> <td colspan="2">39. Fear of heights</td> </tr> </table>		<input type="checkbox"/> Y	<input type="checkbox"/> N	21. Cancer		22. Heart Disease		23. Rheumatic fever		24. Abnormal heartbeat		25. High blood pressure		26. Stroke		27. Serious chest pain		28. Any blood disease		29. Kidney disease		30. Blood in urine		31. Diabetes		32. Headaches/migraine		33. Dizziness/fainting		34. Epilepsy		35. Joints/spinal trouble		36. Surgical operation		37. Serious accident/fracture		38. Tropical disease		39. Fear of heights		<table border="1"> <tr> <td colspan="2">HAVE YOU EVER BEEN -</td> </tr> <tr> <td colspan="2">40. Rejected for employment or insurance for medical reasons</td> </tr> <tr> <td colspan="2">41. Awarded benefits for industrial injury/illness</td> </tr> <tr> <td colspan="2">42. Treated for a mental condition, e.g. depression</td> </tr> <tr> <td colspan="2">43. Treated for problem drinking or drug abuse</td> </tr> <tr> <td colspan="2">44. Exposed to toxic substance or noise</td> </tr> <tr> <td colspan="2">FOR WOMEN ONLY</td> </tr> <tr> <td colspan="2">45. An abnormal smear</td> </tr> <tr> <td colspan="2">46. Any gynaecological treatment</td> </tr> <tr> <td colspan="2">47. Are you pregnant?</td> </tr> <tr> <td colspan="2">48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE</td> </tr> </table>		HAVE YOU EVER BEEN -		40. Rejected for employment or insurance for medical reasons		41. Awarded benefits for industrial injury/illness		42. Treated for a mental condition, e.g. depression		43. Treated for problem drinking or drug abuse		44. Exposed to toxic substance or noise		FOR WOMEN ONLY		45. An abnormal smear		46. Any gynaecological treatment		47. Are you pregnant?		48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE	
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How much tobacco each day? 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:-
 C.R. No: 100037
 PDO RECEPTION
 Socioity hospital

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: Binu
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FOR COMPLETION BY EXAMINING DOCTOR CR NJRSE
Further details of medical history and recreational activities

N = Normal A = Abnormal (please describe)				PHYSICAL EXAMINATION							
N	A			scattered to light							
		1. Eyes & Pupils		N							
		2. E.N.T.		N							
		3. Teeth & Mouth		~							
		4. Lungs & Chest		SISIN							
		5. Cardiovascular System									
		6. Abdominal Viscera		-							
		7. Genital Orifices		-							
		8. Anus & Rectum		S							
		9. Genito-urinary		S							
		10. Extremities									
		11. Musculo-skeletal									
		12. Skin & Varicose Vns.		met N							
		13. C.N.S.									
HEIGHT cm	WEIGHT kg	BMI	B.P. 130 85	PULSE /mins.	HEARING L R	VISION Uncorrected Corrected	DISTANT R L	NEAR R L	Colour Vision	Blood Group	
173	70										
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.)											
FIT ASSESSMENT: <input checked="" type="checkbox"/> FIT ALL AREAS <input type="checkbox"/> FIT WITH RESTRICTION <input type="checkbox"/> TEMPORARY UNFIT <input type="checkbox"/> UNFIT											
Date: Name (Block Capitals): Dr. / Nurse Signature: RECEPTION nmc speciality hospital, Al Hall											
REVIEW/CONSULTATION Date: Name (Block Capitals): Dr. / Nurse Signature: DR. SHAHID KHURSHEED KHAN General Practitioner NMC Lic. No: 21632 nmc speciality hospital, Al Hall											