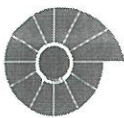


1.1 Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)



**Petroleum Development Oman
MEDICAL DEPARTMENT**

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Surname SREEDHARAN	
Forenames VISWANATHAN	
Address	
Home telephone number	
Employment No #	
Place of examination NMC AL-HAIL	Date:-
If a dependant enter employee's name here:	
Surname:	
Forenames:	
Birth date: 29/05/1968	Nationality: INDIAN
Country of birth:	
Religion:	
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input checked="" 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	21. Cancer
2. Neck swelling/glands	22. Heart Disease
3. Difficulty in vision	23. Rheumatic fever
4. Any ear discharge	24. Abnormal heartbeat
5. Asthma/bronchitis	25. High blood pressure
6. Hayfever /other significant allergy	26. Stroke
7. Any skin trouble	27. Serious chest pain
8. Tuberculosis	28. Any blood disease
9. Shortness of breath	29. Kidney disease
10. Coughed/vomited blood	30. Blood in urine
11. Severe abdominal pain	31. Diabetes
12. Stomach ulcer	32. Headaches/migraine
13. Recurrent indigestion	33. Dizziness/fainting
14. Jaundice or hepatitis	34. Epilepsy
15. Gall Bladder disease	35. Joints/spinal trouble
16. Marked change in bowel habits	36. Surgical operation
17. Blood in stools (motions)	37. Serious accident/fracture
18. Marked change in weight	38. Tropical disease
19. Varicose veins	39. Fear of heights
20. Lump in breast/armpit	
How much tobacco each day? 10/day	
Average daily alcohol consumption Occasional	
Have you ever taken illicit drugs? <input checked="" type="checkbox"/> PDC test all new/potential employees for illicit/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 PDC reserve the right to dismiss me if it was found that I have purposely withheld important medical information.	
Date: 19/10/22	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	WEIGHT	BM	B.P.	PULSE	HEARING	VISION	Colour Vision	Blood Group
162 cm	72 kg	25.2	120/80	62/min.	L N R N	DISTANT R L Uncorrected 6/6 Corrected 6/6 NEAR R L N N	Normal	

N	A		LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A	
<input checked="" type="checkbox"/>		1. Urinalysis	urinary tract infected	<input checked="" type="checkbox"/>		7. Audiogram
<input checked="" type="checkbox"/>		2. Hb, Blood count, ESR		<input checked="" type="checkbox"/>		8. Lung Function
<input checked="" type="checkbox"/>		3. LFT, RFT, RBS				9. Chest X-Ray
<input checked="" type="checkbox"/>		4. Drug Screen		<input checked="" type="checkbox"/>		10. ECG
<input checked="" type="checkbox"/>		5. Lipids (40 years +)		<input checked="" type="checkbox"/>		11. CVS risk for 40 yrs. & above
<input checked="" type="checkbox"/>		6. Sick Cell test				12. HIV, Hepatitis screening

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

ASSESSMENT:

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

FIT



REVIEW/CONSULTATION

DATE: 25/01/2022

DOCTOR NAME: DR. SHIVA KUMAR

SIGNATURE:

DR. SHIVA KUMAR SIDDABAH
General Practitioner
MOH Lic. No. 5076
nmc specialty hospital, Al Hail