

Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)



**Petrochem Development Oman
MEDICAL DEPARTMENT**

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Surname MD		Forenames DABLU HOWLADER	
Address		Home telephone number 95418231	
Place of examination NMC-AI HAIL	Date 12/09/2022		
If a dependant enter employee's name here: Surname: MD Forenames: DABLU HOWLADER			
Birth date: 10/02/1971	Nationality: BANGLADESHI	Country of birth: BANGLADESH	Religion: MUSLIM
<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 checked="" type="checkbox"/> Son <input type="checkbox"/> Daughter	Number of children: 2
Reason for examination Pre-Employment <input checked="" type="checkbox"/> Job: Pre-Overseas <input checked="" 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		<input checked="" type="checkbox"/>	21. Cancer
2. Neck swelling/glands		<input checked="" type="checkbox"/>	22. Heart Disease
3. Difficulty in vision		<input checked="" type="checkbox"/>	23. Rheumatic fever
4. Any ear discharge		<input checked="" type="checkbox"/>	24. Abnormal heartbeat
5. Asthma/bronchitis		<input checked="" type="checkbox"/>	25. High blood pressure
6. Hayfever /other significant allergy		<input checked="" type="checkbox"/>	26. Stroke
7. Any skin trouble		<input checked="" type="checkbox"/>	27. Serious chest pain
8. Tuberculosis		<input checked="" type="checkbox"/>	28. Any blood disease
9. Shortness of breath		<input checked="" type="checkbox"/>	29. Kidney disease
10. Coughed/vomited blood		<input checked="" type="checkbox"/>	30. Blood in urine
11. Severe abdominal pain		<input checked="" type="checkbox"/>	31. Diabetes
12. Stomach ulcer		<input checked="" type="checkbox"/>	32. Headaches/migraine
13. Recurrent indigestion		<input checked="" type="checkbox"/>	33. Dizziness/fainting
14. Jaundice or hepatitis		<input checked="" type="checkbox"/>	34. Epilepsy
15. Gall Bladder disease		<input checked="" type="checkbox"/>	35. Joints/spinal trouble
16. Marked change in bowel habits		<input checked="" type="checkbox"/>	36. Surgical operation
17. Blood in stools (motions)		<input checked="" type="checkbox"/>	37. Serious accident/fracture
18. Marked change in weight		<input checked="" type="checkbox"/>	38. Tropical disease
19. Varicose veins		<input checked="" type="checkbox"/>	39. Fear of heights
20. Lump in breast/armpit		<input checked="" type="checkbox"/>	
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 (x) Tuberculosis () Epilepsy (x) Asthma (x) Eczema (x) Heart disease (x) High blood pressure (x) Stroke (x) Blood Disease (x) Cancer ()			
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: 12/09/2022		Signature of Applicant:	

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Specification **DABLU**

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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 168	WEIGHT kg 78	BMI 27.6	B.P. 143 93	PULSE 80/min.	HEARING L R	VISION DISTANT R L NEAR R L Uncorrected Corrected	Colour Vision	Blood Group
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N	A		LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A	
		1. Urinalysis	ALT ↑↑ for further evaluation → high cholesterol LDL for follow up			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.)

ASSESSMENT:

☐ FIT ALL AREAS ☒ FIT WITH RESTRICTION ☐ TEMPORARY UNFIT ☐ UNFIT

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

Dr. Christine

DR. CHRISTINE MAMDOUH LOIT ABDALLA
General Practitioner
MC 41 Lic. No: 17978
nmc speciality hospital, Al-Hail

REVIEW/CONSULTATION

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

Signature:

