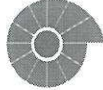
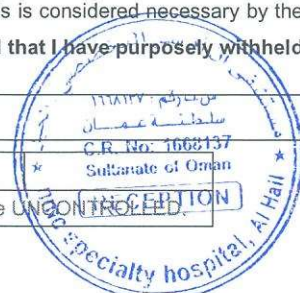


Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

 Petroleum Development Oman MEDICAL DEPARTMENT		Surname <u>KHAN</u>	
PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS		Forenames <u>TARIQ HUSSAIN MUHAMMAD</u>	
		Address <u>AEIM</u>	
Place of examination <u>NMC AL HAIL</u>	Date <u>13-07-23</u>	Home telephone number <u>99685264</u>	
If a dependant enter employee's name here: Surname: _____ Forenames: _____			
Birth date: <u>03-01-1973</u>	Nationality: <u>PAKISTANI</u>	Country of birth: <u>PAKISTAN</u>	Religion: <u>MUSLIM</u>
<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: <u>5</u>
Reason for examination Pre-Employment <input type="checkbox"/> Job: <u>DRIVER</u> 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	Y N
1. Sinus trouble	<input checked="" type="checkbox"/>	21. Cancer	<input checked="" type="checkbox"/>
2. Neck swelling/glands	<input checked="" type="checkbox"/>	22. Heart Disease	<input checked="" type="checkbox"/>
3. Difficulty in vision	<input checked="" type="checkbox"/>	23. Rheumatic fever	<input checked="" type="checkbox"/>
4. Any ear discharge	<input checked="" type="checkbox"/>	24. Abnormal heartbeat	<input checked="" type="checkbox"/>
5. Asthma/bronchitis	<input checked="" type="checkbox"/>	25. High blood pressure	<input checked="" type="checkbox"/>
6. Hayfever /other significant allergy	<input checked="" type="checkbox"/>	26. Stroke	<input checked="" type="checkbox"/>
7. Any skin trouble	<input checked="" type="checkbox"/>	27. Serious chest pain	<input checked="" type="checkbox"/>
8. Tuberculosis	<input checked="" type="checkbox"/>	28. Any blood disease	<input checked="" type="checkbox"/>
9. Shortness of breath	<input checked="" type="checkbox"/>	29. Kidney disease	<input checked="" type="checkbox"/>
10. Coughed/vomited blood	<input checked="" type="checkbox"/>	30. Blood in urine	<input checked="" type="checkbox"/>
11. Severe abdominal pain	<input checked="" type="checkbox"/>	31. Diabetes	<input checked="" type="checkbox"/>
12. Stomach ulcer	<input checked="" type="checkbox"/>	32. Headaches/migraine	<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"/>		
How much tobacco each day? <u>NO</u>		Average daily alcohol consumption <u>NO</u>	
Have you ever taken elicited drugs? (X) PDO test all new/potential employees for elicited/recreational drugs			
FAMILY HISTORY: Diabetes (X) Tuberculosis (X) Epilepsy (X) Asthma (X) Eczema (X) Heart disease (X) High blood pressure (X) Stroke (X) Blood Disease (X) Cancer (X)			
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: <u>13-07-23</u>		Signature of Applicant: <u>[Signature]</u>	



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			Refractive Error → Corrected							
✓		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.	PULSE	HEARING	VISION		Colour Vision	Blood Group
188		89.9		25.4	122 81	64 /mins.	L (N) R (N)	DISTANT R L NEAR R L Uncorrected Corrected		Normal	
N	A			LABORATORY AND OTHER SPECIAL INVESTIGATIONS				N	A		
	✓	1. Urinalysis		Mild urinary infection				✓		7. Audiogram	
✓		2. Hb, Bloodcount, ESR						✓		8. Lung Function	
	✓	3. LFT, RFT, RBS		Elevated blood sugar						9. Chest X-Ray	
		4. Drug Screen		Hypertension				✓		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.)											
Advised Life style modification											
ASSESSMENT:											
<input checked="" type="checkbox"/> FIT ALL AREAS <input type="checkbox"/> FIT WITH RESTRICTION <input type="checkbox"/> TEMPORARY UNFIT <input type="checkbox"/> UNFIT											
Date: 15/07/2023		Name (Block Capitals): DR. SHIVA KUTNAR				Signature: DR. SHIVA KUTNAR					
REVIEW/CONSULTATION											
Date:		Name (Block Capitals): Dr. / Nurse				Signature:					