



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 **NMC A HAIL** Date **26/11/22**Surname **KHAN**
Forenames **TAIMOR HUSSAIN**
Address **98282425**
Home telephone number **98282425**

If a dependant: enter employee's name here:

Surname: **KHAN**Forenames: **TAIMOR HUSSAIN**Birth date: **23/01/1965** Nationality: **PAKISTANI**Country of birth: **PAKISTAN** Religion: **MUSLIM** Male Female Married Single Separated /Divorced Wife Son DaughterNumber of
children: **—**

Reason for examination

Pre-Employment

 Job:

Pre-Overseas

 Area:

Name and address of family doctor

List your last 3 jobs

(1)

(2)

Are you a Registered Disabled Person? (UK only) Do you belong to any Medical Insurance Scheme?

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"/>	<input type="checkbox"/>	21. Cancer	<input checked="" type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER BEEN:-		
2. Neck swelling/glands	<input checked="" type="checkbox"/>	<input type="checkbox"/>	22. Heart Disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>	40. Rejected for employment or insurance for medical reasons		
3. Difficulty in vision	<input checked="" type="checkbox"/>	<input type="checkbox"/>	23. Rheumatic fever	<input checked="" type="checkbox"/>	<input type="checkbox"/>	41. Awarded benefits for industrial injury/illness		
4. Any ear discharge	<input checked="" type="checkbox"/>	<input type="checkbox"/>	24. Abnormal heartbeat	<input checked="" type="checkbox"/>	<input type="checkbox"/>	42. Treated for a mental condition, e.g. depression		
5. Asthma/Bronchitis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	25. High blood pressure	<input checked="" type="checkbox"/>	<input type="checkbox"/>	43. Treated for problem drinking or drug abuse		
6. Hayfever or other significant allergy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	26. Stroke	<input checked="" type="checkbox"/>	<input type="checkbox"/>	44. Exposed to toxic substance or noise		
7. Any skin trouble	<input checked="" type="checkbox"/>	<input type="checkbox"/>	27. Serious chest pain	<input checked="" type="checkbox"/>	<input type="checkbox"/>	FOR WOMEN ONLY		
8. Tuberculosis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	28. Any blood disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Have you ever had:-		
9. Shortness of breath	<input checked="" type="checkbox"/>	<input type="checkbox"/>	29. Kidney disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>	45. An abnormal smear		
10. Coughed up blood	<input checked="" type="checkbox"/>	<input type="checkbox"/>	30. Blood in urine	<input checked="" type="checkbox"/>	<input type="checkbox"/>	46. Any gynaecological treatment		
11. Severe abdominal pain	<input checked="" type="checkbox"/>	<input type="checkbox"/>	31. Diabetes	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
12. Stomach ulcer	<input checked="" type="checkbox"/>	<input type="checkbox"/>	32. Headaches/migraine	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
13. Recurrent indigestion	<input checked="" type="checkbox"/>	<input type="checkbox"/>	33. Dizziness/fainting	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
14. Jaundice or hepatitis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	34. Epilepsy	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
15. Gall Bladder disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>	35. Joints/spinal trouble	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
16. Marked change in bowel habits	<input checked="" type="checkbox"/>	<input type="checkbox"/>	36. Surgical operation	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
17. Blood in stools (motions)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	37. Serious accident/fracture	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
18. Marked change in weight	<input checked="" type="checkbox"/>	<input type="checkbox"/>	38. Tropical disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
19. Varicose veins	<input checked="" type="checkbox"/>	<input type="checkbox"/>	39. Fear of heights	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
20. Lump in breast/armpit	<input checked="" type="checkbox"/>	<input 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 () Tuberculosis () Epilepsy () Asthma () Eczema ()
 Heart disease () High blood pressure (F) Stroke () Blood Disease () 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: **26/11/22**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 cm	WEIGHT kg	BMI	B.P. 140	PULSE 80/mins.	HEARING L R N	VISION DISTANT R L Uncorrected Corrected 16 16	NEAR R L N N	Colour Vision N	Blood Group
180	101	31.1	90						
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS				N	A		
<input checked="" type="checkbox"/>	1. Urinalysis				<input checked="" type="checkbox"/>	7. Aucioogram			
<input checked="" type="checkbox"/>	2. Hb, Bloodcount, ESR				<input checked="" type="checkbox"/>	8. Lung Function			
<input checked="" type="checkbox"/>	3. LFT, RFT, RBS				<input checked="" type="checkbox"/>	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. Sickle Cell test				<input checked="" type="checkbox"/>	12 HIV, Hepatitis screening			

ASSESSMENT:

FIT ALL AREAS FIT WITH RESTRICTION TEMPORARY UNFIT UNFIT

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

Signature:

REVIEW/CONSULTATION

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

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Specification

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