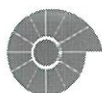




Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

Petrochem Development Oman
MEDICAL DEPARTMENTPLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Surname KHAN		Forenames TAJMOOR HUSSEIN	
Address			
Place of examination NMC AHAIL		Date 28/11/22	
Home telephone number 98282425			
If a dependant: enter employee's name here:			
Surname: KHAN		Forenames: TAJMOOR HUSSEIN	
Birth date: 23/01/1965		Nationality: PAKISTANI	
Country of birth: PAKISTAN		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 checked="" 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	
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. Hay fever/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? X		Average daily alcohol consumption X	
Have you ever taken illicit drugs? X PDO test all new/potential employees for illicit/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: 28/11/22		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.	PULSE	HEARING	VISION	Colour Vision	Blood Group
180	101	31.17	140/90	80/min.	L: N R: N	DISTANT R: 6/6 L: 6/6 NEAR R: N L: N Uncorrected Corrected	N	

N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A	
<input checked="" type="checkbox"/>		1. Urinalysis	<input checked="" type="checkbox"/>		7. Audiogram
<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

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

Signature:

REVIEW/CONSULTATION

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

Signature:

