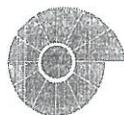


1.1 Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)



Petroleum Development Oman MEDICAL DEPARTMENT

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Place of examination		Date:-		Surname _____			
				Forenames _____			
				Address _____			
				Home telephone number _____			
				Employment No # _____			
If a dependant enter employee's name here:							
Surname: _____		Forenames: _____					
Birth date:	Nationality: _____		Country of birth: _____		Religion: _____		
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced		<input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter		Relationship to employee _____ 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					
NMC Al Hamra		(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.)							
1. Sinus trouble		Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	21. Cancer		Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	HAVE YOU EVER BEEN:-	
2. Neck swelling/glands		Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	22. Heart Disease		Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	40. Rejected for employment or insurance for medical reasons	
3. Difficulty in vision		Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	23. Rheumatic fever		Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	41. Awarded benefits for industrial injury/illness	
4. Any ear discharge		Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	24. Abnormal heartbeat		Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	42. Treated for a mental condition, e.g. depression	
5. Asthma/bronchitis		Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	25. High blood pressure		Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	43. Treated for problem drinking or drug abuse	
6. Hayfever /other significant allergy		Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	26. Stroke		Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	44. Exposed to toxic substance or noise	
7. Any skin trouble		Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	27. Serious chest pain		Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	FOR WOMEN ONLY	
8. Tuberculosis		Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	28. Any blood disease		Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	Have you ever had:-	
9. Shortness of breath		Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	29. Kidney disease		Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	45. An abnormal smear	
10. Coughed/vomited blood		Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	30. Blood in urine		Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	46. Any gynaecological treatment	
11. Severe abdominal pain		Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	31. Diabetes		Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	47. Are you pregnant?	
12. Stomach ulcer		Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	32. Headaches/migraine		Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE	
13. Recurrent Indigestion		Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	33. Dizziness/fainting		Y <input type="checkbox"/> N <input checked="" type="checkbox"/>		
14. Jaundice or hepatitis		Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	34. Epilepsy		Y <input type="checkbox"/> N <input checked="" type="checkbox"/>		
15. Gall Bladder disease		Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	35. Joints/spinal trouble		Y <input type="checkbox"/> N <input checked="" type="checkbox"/>		
16. Marked change in bowel habits		Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	36. Surgical operation		Y <input type="checkbox"/> N <input checked="" type="checkbox"/>		
17. Blood in stools (motions)		Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	37. Serious accident/fracture		Y <input type="checkbox"/> N <input checked="" type="checkbox"/>		
18. Marked change in weight		Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	38. Tropical disease		Y <input type="checkbox"/> N <input checked="" type="checkbox"/>		
19. Varicose veins		Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	39. Fear of heights		Y <input type="checkbox"/> N <input checked="" type="checkbox"/>		
20. Lump in breast/armpit		Y <input type="checkbox"/> N <input checked="" type="checkbox"/>			Y <input type="checkbox"/> N <input checked="" type="checkbox"/>		
How much tobacco each day? <input type="checkbox"/> No		Average daily alcohol consumption <input type="checkbox"/> No					
Have you ever taken elicited drugs? () PDO test all new/potential employees for elicited/recreational drugs							
FAMILY HISTORY:		Diabetes () Heart disease ()	Tuberculosis () High blood pressure ()	Epilepsy () Stroke ()	Asthma () Blood Disease ()	Eczema () Cancer ()	
PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT:-							
I declare 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: _____		Signature of Applicant: _____					
RECEPTION							

RECEPTION

RECEPTION

RECEPTION

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	WEIGHT kg	BM I	B.P. —	PULSE /mins.	HEARING L R	VISION				Colour Vision	Blood Group
						DISTANT R L	Uncorrected R L	Corrected R L	NEAR		
180	93.9	28.9	153/97	70		6 6			+	N	

N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A
	✓	1. Urinalysis	✓	7. Audiogram
✓		2. Hb, Blood count, 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 SPECIFIC RESTRICTION
- TEMPORARY UNFIT
- AWAITING SPECIALIST ASSESSMENT

Marked medical convolution
in view of Hypertension,
Albuminuria (proteinuria) and
Dyslipidemia

REVIEW/CONSULTATION

DATE: 9/8/2022 DOCTOR NAME: DR. SHAFRAZ KHAN SIGNATURE:

