

# 1427

5

## 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 28.03.2019		Surname CORPREET SINGH																																																																																			
				Forenames																																																																																			
				Address																																																																																			
				Home telephone number																																																																																			
				Employment No # 1427																																																																																			
If a dependant enter employee's name here:																																																																																							
Surname:		Forenames:																																																																																					
Birth date: 20/10/1975		Nationality: INDIAN		Country of birth: Religion:																																																																																			
<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																																																																																			
Reason for examination		Pre-Employment <input type="checkbox"/>		Job: Driver																																																																																			
		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.)																																																																																							
<table border="1"> <tr> <th>Y</th> <th>N</th> </tr> <tr> <td colspan="2">1. Sinus trouble</td> </tr> <tr> <td colspan="2">2. Neck swelling/glands</td> </tr> <tr> <td colspan="2">3. Difficulty in vision</td> </tr> <tr> <td colspan="2">4. Any ear discharge</td> </tr> <tr> <td colspan="2">5. Asthma/bronchitis</td> </tr> <tr> <td colspan="2">6. Hayfever /other significant allergy</td> </tr> <tr> <td colspan="2">7. Any skin trouble</td> </tr> <tr> <td colspan="2">8. Tuberculosis</td> </tr> <tr> <td colspan="2">9. Shortness of breath</td> </tr> <tr> <td colspan="2">10. Coughed/vomited blood</td> </tr> <tr> <td colspan="2">11. Severe abdominal pain</td> </tr> <tr> <td colspan="2">12. Stomach ulcer</td> </tr> <tr> <td colspan="2">13. Recurrent indigestion</td> </tr> <tr> <td colspan="2">14. Jaundice or hepatitis</td> </tr> <tr> <td colspan="2">15. Gall Bladder disease</td> </tr> <tr> <td colspan="2">16. Marked change in bowel habits</td> </tr> <tr> <td colspan="2">17. Blood in stools (motions)</td> </tr> <tr> <td colspan="2">18. Marked change in weight</td> </tr> <tr> <td colspan="2">19. Varicose veins</td> </tr> <tr> <td colspan="2">20. Lump in breast/armpit</td> </tr> </table>		Y	N	1. Sinus trouble		2. Neck swelling/glands		3. Difficulty in vision		4. Any ear discharge		5. Asthma/bronchitis		6. Hayfever /other significant allergy		7. Any skin trouble		8. Tuberculosis		9. Shortness of breath		10. Coughed/vomited blood		11. Severe abdominal pain		12. Stomach ulcer		13. Recurrent indigestion		14. Jaundice or hepatitis		15. Gall Bladder disease		16. Marked change in bowel habits		17. Blood in stools (motions)		18. Marked change in weight		19. Varicose veins		20. Lump in breast/armpit		<table border="1"> <tr> <th>Y</th> <th>N</th> </tr> <tr> <td colspan="2">21. Cancer</td> </tr> <tr> <td colspan="2">22. Heart Disease</td> </tr> <tr> <td colspan="2">23. Rheumatic fever</td> </tr> <tr> <td colspan="2">24. Abnormal heartbeat</td> </tr> <tr> <td colspan="2">25. High blood pressure</td> </tr> <tr> <td colspan="2">26. Stroke</td> </tr> <tr> <td colspan="2">27. Serious chest pain</td> </tr> <tr> <td colspan="2">28. Any blood disease</td> </tr> <tr> <td colspan="2">29. Kidney disease</td> </tr> <tr> <td colspan="2">30. Blood in urine</td> </tr> <tr> <td colspan="2">31. Diabetes</td> </tr> <tr> <td colspan="2">32. Headaches/migraine</td> </tr> <tr> <td colspan="2">33. Dizziness/fainting</td> </tr> <tr> <td colspan="2">34. Epilepsy</td> </tr> <tr> <td colspan="2">35. Joints/spinal trouble</td> </tr> <tr> <td colspan="2">36. Surgical operation</td> </tr> <tr> <td colspan="2">37. Serious accident/fracture</td> </tr> <tr> <td colspan="2">38. Tropical disease</td> </tr> <tr> <td colspan="2">39. Fear of heights</td> </tr> </table>		Y	N	21. Cancer		22. Heart Disease		23. Rheumatic fever		24. Abnormal heartbeat		25. High blood pressure		26. Stroke		27. Serious chest pain		28. Any blood disease		29. Kidney disease		30. Blood in urine		31. Diabetes		32. Headaches/migraine		33. Dizziness/fainting		34. Epilepsy		35. Joints/spinal trouble		36. Surgical operation		37. Serious accident/fracture		38. Tropical disease		39. Fear of heights		HAVE YOU EVER BEEN:- 40. Rejected for employment or insurance for medical reasons 41. Awarded benefits for industrial injury/illness 42. Treated for a mental condition, e.g. depression 43. Treated for problem drinking or drug abuse 44. Exposed to toxic substance or noise FOR WOMEN ONLY Have you ever had:- 45. An abnormal smear 46. Any gynaecological treatment 47. Are you pregnant? 48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE	
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How much tobacco each day? <input type="checkbox"/> Average daily alcohol consumption <input type="checkbox"/>																																																																																							
Have you ever taken elicited drugs? ( ) PDO test all new/potential employees for elicited/recreational drugs																																																																																							
FAMILY HISTORY: Diabetes <input checked="" type="checkbox"/> Tuberculosis <input checked="" type="checkbox"/> Epilepsy <input checked="" type="checkbox"/> Asthma <input checked="" type="checkbox"/> Eczema <input checked="" type="checkbox"/> Heart disease <input checked="" type="checkbox"/> High blood pressure <input checked="" type="checkbox"/> Stroke <input checked="" type="checkbox"/> Blood Disease <input checked="" type="checkbox"/> Cancer <input checked="" type="checkbox"/>																																																																																							
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: 28.3.19		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														
✓		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 160		WEIGHT kg 67	BM 26.17	B.P. 130 / 90	PULSE 76 /mins.	HEARING L R	VISION DISTANT R L				Uncorrected 6/6 6/6	NEAR R L	Corrected n/6 n/6	Colour Vision (N)	Bloc- Group
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.)

FRAMMINGTON RISK SCORE : 2.0 %

ASSESSMENT:

- FIT ALL AREAS
- FIT WITH SPECIFIC RESTRICTION
- TEMPORARY UNFIT
- AWAITING SPECIALIST ASSESSMENT

Dyslipidemia  
Ad lib. smoking and alcohol  
To R/T Cigarette after 3 months

REVIEW/CONSULTATION

DATE: 02/04/19

SIGNATURE:

