

**EXAMINATION FORM - QUESTIONNAIRE**  
**PERSONAL DETAILS**

Family name:

Christian name:

Address:

Tel No:

Other Address:

Tel No:

Date of Birth:

Marital Status: M / S / D / W

GP's Name:

GP's Address:

Offshore Occupation/Job Title:

Date of Last Offshore Medical:

Date of Last Survival Course:

Fire Team Member: Yes/No (circle)

**SOCIAL/OCCUPATIONAL HISTORY**

**Write in answers**

1. Do you smoke? If so, how many per day?

2. If an ex-smoker, when did you give up?

3. Average weekly alcohol consumption: state quantity and type

4. Have you been exposed to any known occupational hazard *such as noise, radiation, dusts, asbestos, chemicals or lead?*

5. Have you used protective clothing, safety glasses or hearing protection?

6. Have you ever developed any medical condition in connection with your occupation? If so please give details *e.g. hearing loss / skin condition / Wheeze / backache / muscle strain / blood disease?*

7. Have you suffered any industrial injury? If so please give details:

8. Have you had any previous audiometric screening? Was this normal?  
State when and where.

9. Have you had previous lung function screening? Was this normal?

State when and where.

10. Have you ever been rejected from employment on medical grounds?

11. Have you received compensation, or is there any industrial claim pending?

12. Have you ever been medivaced from an offshore installation?

#### **EXAMINING PHYSICIAN'S COMMENTS**

#### **MEDICAL HISTORY REQUIRING SPECIAL CONSIDERATION**

**DO YOU HAVE OR HAVE YOU BEEN DIAGNOSED AS SUFFERING FROM ANY OF THE FOLLOWING?** Please circle and elaborate

1. Chest pain/ heart disease YES NO

2. High blood pressure 1 stroke YES NO

3. Asthma / Epilepsy / Diabetes YES NO

4. Peptic ulcer disease YES NO

5. Kidney disease (*e.g. stones*) YES NO

6. Psychiatric disorder (*e.g. anxiety, YES NO depression YES NO*)

7. Tuberculosis YES NO

8. Cancer YES NO

**DO ANY OF YOUR IMMEDIATE FAMILY (PARENTS/BROTHERS/SISTERS) HAVE A HISTORY OF ANY OF THE ABOVE CONDITIONS? PLEASE SPECIFY:**

#### **EXAMINING PHYSICIAN'S COMMENTS**

**DO YOU HAVE OR HAVE YOU HAD ANY SIGNIFICANT OR RECURRENT PROBLEMS WITH THE FOLLOWING?** Please circle and elaborate

1. Backache / joint or muscular pain YES NO

2. Hernia/ rupture YES NO

3. Visual impairment YES NO

4. Perforated eardrum /discharge from ear YES NO
5. Do you have a regular dentist? Details (name, address, etc)
  - When was your last visit?
  - What was this for? Do you have more appointments?
  - Do you have any toothache?
  - Do your teeth ache after eating and drinking?
  - Do your gums bleed spontaneously or after brushing?
  - Do you wear false teeth?
6. Recurrent indigestion YES NO
7. Jaundice / hepatitis / gall bladder disease YES NO
8. Change in bowel habit / diarrhoea YES NO
9. Blood in stool / piles, haemorrhoids YES NO
10. Shortness of breath / coughing up blood YES NO
11. Recurrent bronchitis / pneumonia YES NO
12. Blood in urine / kidney complications YES NO stones YES NO
13. Headaches / migraine 1 dizziness YES NO
14. Varicose veins YES NO
15. Skin trouble (*e.g. dermatitis / eczema*) YES NO
16. Surgical operations YES NO
17. Hospitalisation YES NO
18. Fear of flying / fear of heights YES NO
19. Tropical diseases / venereal disease YES NO
20. History of alcohol / drug abuse YES NO
21. Do you have any allergies? Please list YES NO
22. Do have any current illnesses? Please list YES NO
23. Are you receiving any medication, including vitamins, etc, at present? YES NO  
Please list

24. Travellers Vaccinations: Date of Last Booster:

Tetanus Diphtheria

Polio Hep A

Typhoid Hep B

Yellow Fever Others

**FOR FEMALES ONLY - HAVE YOU EVER HAD?**

Please circle and elaborate

25. An abnormal smear / breast disease YES NO

26. Gynaecological problems *e.g. pelvic infection* YES NO

27. Complications of Pregnancy YES NO

28. Please give date of last menstrual period

**EXAMINING PHYSICIAN'S COMMENTS**

"I declare the above to be true to the best of my knowledge. I agree the result of my medical examination, including appropriate investigations carried out in order to establish medical fitness may be revealed to a company medical officer if required. I accept the transfer of my medical files to either doctors working for the company in which I may gain employment"

**Non-declaration of significant medical problems may result in termination of employment.**

**Signature of examinee:** .....

**Date:** .....