Patient to complete pages 1–4 only

NORTH YORKSHIRE MEDICALS

Medical screening questionnaire and examination record

Surname: Forename(s):

Address:

Date of birth: Tel no:

GP surgery:

Date of last offshore/ENG/RUK medical:

Current employer name:

Offshore platform/vessel type:

Job role:

Emergency response role:

Social/occupational history	Yes	No	Comments
1. Do you smoke? If yes, 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 ever been exposed to any known occupational hazard such as noise, radiation, dusts, asbestos, chemicals or lead?	○	○	
5. Do you use 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 eg hearing loss/skin condition/wheeze/backache/muscle strain/blood disease?	○	○	
7. Have you ever suffered any industrial injury? If so, please give details.	○	○	

PTO...

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NORTH YORKSHIRE MEDICALS

Medical screening questionnaire and examination record (continued)

Social/occupational history	Yes	No	Comments
8. Have you ever had any previous audiometric (hearing) screening? Was this normal? State when and where.	○	○	
9. Have you ever 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 ever received compensation or is there any industrial claim pending?	○	○	
12. Have you ever been medevaced from an offshore installation?	○	○	

Do you have or have you been diagnosed as suffering from any of the following?	Yes	No	(Please select and elaborate)
1. Chest pain/heart pain	○	○	
2. High blood pressure/stroke	○	○	
3. Asthma/epilepsy/diabetes	○	○	
4. Peptic (stomach) ulcer disease	○	○	
5. Kidney disease (eg stones)	○	○	
6. Psychiatric disorder (eg anxiety, depression)	○	○	
7. Tuberculosis	○	○	
8. Cancer	○	○	

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NORTH YORKSHIRE MEDICALS

Medical screening questionnaire and examination record (continued)

Do any of your immediate family (parents/brothers/sisters) have a history of any of these conditions? Please specify:

Please list all medications (including dosage) you are currently prescribed

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Patient to complete pages 1–4 only

NORTH YORKSHIRE MEDICALS

Medical screening questionnaire and examination record (continued)

Have you ever suffered from any of the following?	Yes	No	
1. Backache/joint or muscular pain	◯	◯	
2. Hernia/rupture	◯	◯	
3. Visual impairment	◯	◯	
4. Do you wear glasses/contact lenses?	◯	◯	
5. If yes to above, do you have spares at work?	◯	◯	
6. Perforated eardrum/discharge from ear	◯	◯	
7. Do you have a hearing impairment?	◯	◯	
8. Recurrent indigestion or other abdominal disorder	◯	◯	
9. Jaundice/hepatitis/gall bladder disease	◯	◯	
10. Change in bowel habit/diarrhoea	◯	◯	
11. Blood in stools/piles/haemorrhoids	◯	◯	
12. Shortness of breath/coughing up blood	◯	◯	
13. Recurrent bronchitis/pneumonia	◯	◯	
14. Blood in urine/kidney complications/stones	◯	◯	
15. Headaches/migraine/dizziness	◯	◯	
16. Previous head injury	◯	◯	
17. Obstetric/gynaecological problems (if female)	◯	◯	
18. Skin diseases	◯	◯	
19. Hayfever or allergies	◯	◯	
20. Sleep disorders	◯	◯	
21. Dental problems	◯	◯	
22. What is your approximate weight?			

I certify that the above information is correct.

Signed: _____

(Please type name in box above) [employee]

SEND FORM

or save it and email to:
drlittle@nymedicals.co.uk

Medical screening questionnaire and examination record (continued)

TO BE COMPLETED BY EXAMINING PRACTITIONER

Examining physician comments on history:

Photographic ID

Passport no: Driver's licence no:

Other:

Height	Weight	BMI	BP	Pulse	FEV_1	FVC	FEV_1 /FVC	Urinalysis		
								Protein	Blood	Glucose

Medical screening questionnaire and examination record (continued)

TO BE COMPLETED BY EXAMINING PRACTITIONER

Vision – distance		
L	UnAided	Aided
R	UnAided	Aided

Vision – near		
L	Aided L	Both
R	Aided R	

Colour	
Normal	Abnormal
○	○

VDU

	N	A	Comment
Audiometric Screening	○	○	
Substance Abuse Screening	○	○	
Stool Culture (Catering Crew)	○	○	

	Normal	Abnormal	Comments
1. Eyes/pupils	○	○	
2. Ear, nose and throat	○	○	
3. Teeth	○	○	
4. Lungs/chest	○	○	
5. Cardiovascular	○	○	
6. Abdomen	○	○	
7. Hernial orifices	○	○	

Medical screening questionnaire and examination record (continued)

TO BE COMPLETED BY EXAMINING PRACTITIONER

	Normal	Abnormal	Comments
8. Genitourinary	○	○	
9. Musculoskeletal	○	○	
10. Skin	○	○	
11. Varicose veins	○	○	
12. Neurological	○	○	

Physician to comment on any abnormalities:

Certification	**Comment/reason**
○ Fit for offshore work as per OGUK guidelines	
○ Fit for restricted offshore work following discussion with operating company's medical adviser	
○ Temporarily unfit for offshore work	
○ Permanently unfit for offshore work	

Examining physician name: **Dr J G Little – BSc (hons), MRes, MBChB, DOccMed, MRCGP**

Signed: Date of examination: