



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: _____

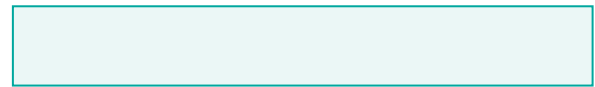
Social/occupational history	Yes	No	Comments
1. Do you smoke? If yes, how many per day?	<input type="radio"/>	<input type="radio"/>	
2. If an ex-smoker, when did you give up?	<input type="radio"/>	<input type="radio"/>	
3. Average weekly alcohol consumption - state quantity and type	<input type="radio"/>	<input type="radio"/>	
4. Have you ever been exposed to any known occupational hazard such as noise, radiation, dusts, asbestos, chemicals or lead?	<input type="radio"/>	<input type="radio"/>	
5. Do you use protective clothing, safety glasses or hearing protection?	<input type="radio"/>	<input type="radio"/>	
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?	<input type="radio"/>	<input type="radio"/>	
7. Have you ever suffered any industrial injury? If so, please give details.	<input type="radio"/>	<input type="radio"/>	

PTO...

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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



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



Medical screening questionnaire and examination record (continued)

Have you ever suffered from any of the following? Yes / No

1. Backache/joint or muscular pain	<input type="radio"/>	<input type="radio"/>	
2. Hernia/rupture	<input type="radio"/>	<input type="radio"/>	
3. Visual impairment	<input type="radio"/>	<input type="radio"/>	
4. Do you wear glasses/contact lenses?	<input type="radio"/>	<input type="radio"/>	
5. If yes to above, do you have spares at work?	<input type="radio"/>	<input type="radio"/>	
6. Perforated eardrum/discharge from ear	<input type="radio"/>	<input type="radio"/>	
7. Do you have a hearing impairment?	<input type="radio"/>	<input type="radio"/>	
8. Recurrent indigestion or other abdominal disorder	<input type="radio"/>	<input type="radio"/>	
9. Jaundice/hepatitis/gall bladder disease	<input type="radio"/>	<input type="radio"/>	
10. Change in bowel habit/diarrhoea	<input type="radio"/>	<input type="radio"/>	
11. Blood in stools/piles/haemorrhoids	<input type="radio"/>	<input type="radio"/>	
12. Shortness of breath/coughing up blood	<input type="radio"/>	<input type="radio"/>	
13. Recurrent bronchitis/pneumonia	<input type="radio"/>	<input type="radio"/>	
14. Blood in urine/kidney complications/stones	<input type="radio"/>	<input type="radio"/>	
15. Headaches/migraine/dizziness	<input type="radio"/>	<input type="radio"/>	
16. Previous head injury	<input type="radio"/>	<input type="radio"/>	
17. Obstetric/gynaecological problems (if female)	<input type="radio"/>	<input type="radio"/>	
18. Skin diseases	<input type="radio"/>	<input type="radio"/>	
19. Hayfever or allergies	<input type="radio"/>	<input type="radio"/>	
20. Sleep disorders	<input type="radio"/>	<input type="radio"/>	
21. Dental problems	<input type="radio"/>	<input type="radio"/>	
22. What is your approximate weight?			

I certify that the above information is correct.

Signed: _____
(Please type name in box above) [employee]



**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			Vision - near			Colour		VDU
L	UnAided	Aided	L	Aided L	Both	Normal	Abnormal	
R	UnAided	Aided	R	Aided R				

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

	Normal	Abnormal	Comments
1. Eyes/pupils	<input type="radio"/>	<input type="radio"/>	
2. Ear, nose and throat	<input type="radio"/>	<input type="radio"/>	
3. Teeth	<input type="radio"/>	<input type="radio"/>	
4. Lungs/chest	<input type="radio"/>	<input type="radio"/>	
5. Cardiovascular	<input type="radio"/>	<input type="radio"/>	
6. Abdomen	<input type="radio"/>	<input type="radio"/>	
7. Hernial orifices	<input type="radio"/>	<input type="radio"/>	

Medical screening questionnaire and examination record (continued)

TO BE COMPLETED BY EXAMINING PRACTITIONER

	Normal	Abnormal	Comments
8. Genitourinary	<input type="radio"/>	<input type="radio"/>	
9. Musculoskeletal	<input type="radio"/>	<input type="radio"/>	
10. Skin	<input type="radio"/>	<input type="radio"/>	
11. Varicose veins	<input type="radio"/>	<input type="radio"/>	
12. Neurological	<input type="radio"/>	<input type="radio"/>	

Physician to comment on any abnormalities:

Certification

Comment/reason

Fit for offshore work as per OGUK guidelines

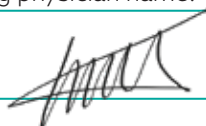
Fit for restricted offshore work following discussion with operating company's medical adviser

Temporarily unfit for offshore work

Permanently unfit for offshore work

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

Signed:



Date of examination: