



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?			
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)

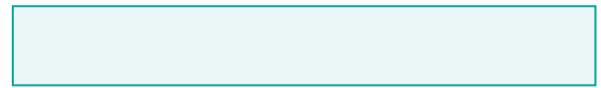
Social/occupational history

	Yes	No	Comments
8. Have you ever had any previous audiometric (hearing) screening? Was this normal? State when and where.	<input type="radio"/>	<input type="radio"/>	
9. Have you ever had previous lung function screening? Was this normal? State when and where.	<input type="radio"/>	<input type="radio"/>	
10. Have you ever been rejected from employment on medical grounds?	<input type="radio"/>	<input type="radio"/>	
11. Have you ever received compensation or is there any industrial claim pending?	<input type="radio"/>	<input type="radio"/>	
12. Have you ever been medevaced from an offshore installation?	<input type="radio"/>	<input type="radio"/>	

Do you have or have you been diagnosed as suffering from any of the following?

Yes No (Please select and elaborate)

	Yes	No	(Please select and elaborate)
1. Chest pain/heart pain	<input type="radio"/>	<input type="radio"/>	
2. High blood pressure/stroke	<input type="radio"/>	<input type="radio"/>	
3. Asthma/epilepsy/diabetes	<input type="radio"/>	<input type="radio"/>	
4. Peptic (stomach) ulcer disease	<input type="radio"/>	<input type="radio"/>	
5. Kidney disease (eg stones)	<input type="radio"/>	<input type="radio"/>	
6. Psychiatric disorder (eg anxiety, depression)	<input type="radio"/>	<input type="radio"/>	
7. Tuberculosis	<input type="radio"/>	<input type="radio"/>	
8. Cancer	<input type="radio"/>	<input type="radio"/>	



Medical screening questionnaire and examination record (continued)

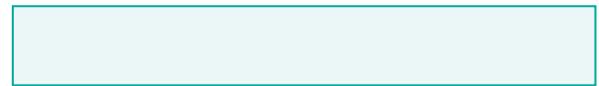
Do any of your immediate family (parents/brothers/sisters) have a history of any of these conditions? Please specify:

A large, empty rectangular area with a light blue gradient background, intended for the user to specify any family medical history.

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

A large, empty rectangular area with a light blue gradient background, intended for the user to list all currently prescribed medications and their dosages.

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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