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...

NORTH YORKSHIRE MEDICALS LTD
Tel: +44 (0)7593 565176
drlittle@nymedicals.co.uk

Churchfield Surgery, Iburndale Lane, Sleights, Whitby, North Yorkshire, YO22 5DP
Sandsend Surgery, Sandsend Road, Sandsend, Whitby, North Yorkshire, YO21 3SN

www.nymedicals.co.uk

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	○	○	

PTO...

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

PTO...

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