Schlumberger

Med-Track
SCHLUMBERGER PHYSICAL

Confidential Medical

NAME of RECRUITER .....

PRE-EMPLOYMENT ☐

PERIODIC CHECK-UP ☐

Dear Schlumberger Employee,

Please be kind enough to fill out the first 2 pages of this medical questionnaire as completely as possible and **give all pages to the examining physician, who will fill out his part.**

Thank you for your cooperation.

Sincerely,
Doctor Alex Barbey, International Health Coordinator, Schlumberger & SAMI

TO BE COMPLETED BY THE SCHLUMBERGER EMPLOYEE

Please Write in Clear Capital Letters in ENGLISH (pages 1 and 2)

EMPLOYEE'S LAST NAME ..... FIRST NAME .....

SEX ..... BIRTH DATE (day/month/year) .....

HOME PHONE ..... NATIONALITY .....

HOME ADDRESS .....

SCHLUMBERGER COMPANY .....

EMPLOYEE COMPANY NUMBER (GIN) .....

JOB DESCRIPTION .....

AREA AND PRESENT JOB LOCATION (COUNTRY) .....

Please read the following statement and if you agree, kindly sign it:

All medical information will remain strictly confidential and employees who wish to consult or rectify their medical files may do so by writing to the Medical Department-Schlumberger Paris (Art. 27-CNIL).

I declare these statements to be true to the best of my knowledge and I agree that the results of this medical examination will be sent to the Medical Department-Schlumberger.

Date (day/month/year) ..... Signature of employee .....

EMPLOYEE'S NAME .....

Please fill in if you know your blood group: BLOOD GROUP

DO YOU HAVE OR HAVE YOU HAD…

Check "Yes" or "No" column (or put "?" if uncertain):

	Yes	No
1. sinus trouble		
2. neck swelling/glands		
3. difficulty in vision		
4. any ear discharge		
5. asthma/bronchitis		
6. hayfever/other allergy		
7. any skin trouble		
8. tuberculosis		
9. shortness of breath		
10. coughed blood		
11. abdominal pain		
12. stomach ulcer		
13. recurrent indigestion		
14. jaundice/hepatitis		
15. gall bladder disease		
16. marked change in bowel habits		
17. blood in stool		
18. change in weight		
19. varicose veins		
20. lump in breast		

	Yes	No
21. cancer		
22. heart disease		
23. rheumatic fever		
24. abnormal heartbeat		
25. high blood pressure		
26. stroke		
27. serious chest pain		
28. any blood disease		
29. kidney disease		
30. painful passage urine		
31. blood in urine		
32. diabetes		
33. headaches/migraine		
34. dizziness/fainting		
35. epilepsy		
36. joints/spinal trouble		
37. surgical operation		
38. accident/fracture		
39. tropical disease		
40. fear of heights		

	Yes	No
Have you ever been…		
41. rejected for employment or insurance for medical reasons		
42. awarded benefits for industrial injury		
43. treated for a mental condition		
44. treated for drinking problem/ drug abuse		
45. exposed to:		
Mercury		
Radioactivity		
Toxic chemicals		
Excessive noise		
FOR WOMEN ONLY:		
Have you ever had…		
46. an abnormal PAP smear		
47. a gynecological treatment		
48. Are you pregnant?		

If you answered "Yes" for 37, 38 and 39 or if you have or had an illness not mentioned above, please give details in clear capital letters IN ENGLISH .....
.....
.....

Do you take preventative Malaria medication when in high-risk areas? Yes ☐ No ☐
If Yes, which medication? .....

Other medication taken regularly: .....
Allergies to medication: .....
.....

DATES OF LAST VACCINATIONS: (day/month/year)

polio	…./…../….	hepatitis B	…./…../….	hepatitis A	…./…../….
tetanus	…./…../….	yellow fever	…./…../….	typhoid	…./…../….
other.....	…./…../….	other	…./…../….		

Alcohol consumption: Number of glasses per day? .....
Tobacco smoked: Number of cigarettes per day?.....

EMPLOYEE'S NAME .....

TO BE COMPLETED BY THE EXAMINING PHYSICIAN

Please Write in Clear Capital Letters in ENGLISH or Type if Possible (pages 3 and 4)

PRE-EMPLOYMENT CHECK-UP ONLY: Drug Testing Performed? Yes ☐ No ☐

Please update vaccinations: Indicate vaccinations ***performed during this examination***

Polio ☐ Tetanus ☐ Hepatitis B ☐ Yellow Fever ☐ Hepatitis A ☐ Typhoid ☐

Other Please give details:.....

Please make sure that the patient has correct Malaria protection when travelling to high-risk areas.

MEDICAL EXAMINATION	**normal**	**abnormal**	**IF ABNORMAL, PLEASE GIVE DETAILS**
1. eyes and pupils	n	a	.....
2. ear/nose/throat	n	a	.....
3. teeth and mouth	n	a	.....
4. lungs and chest	n	a	.....
5. cardiovascular	n	a	.....
6. abdo.viscera	n	a	.....
7. hernial orifices	n	a	.....
8. anus and rectum	n	a	.....
9. genito-urinary	n	a	.....
10. extremities	n	a	.....
11. musculo-skeletal	n	a	.....
12. skin/varicose veins	n	a	.....
13. neurological	n	a	.....
14. breast	n	a	.....

HEIGHT		WEIGHT		BLOOD PRESSURE	PULSE	HEARING		VISION		n a	With glasses	COLOR vision
cms	ft/in.	kg	lbs			R	n a	Distant	R L		Yes ☐	
						L	n a	Near	R L		No ☐	

EMPLOYEE'S NAME .....

PARA-CLINICAL EXAMINATION

ECG n a .....
Chest X-ray n a .....

Only for Pre-employment or if medically justified:
Lumbar X-ray n a .....

BLOOD

RBC	.....M/mm^3	SGOT (ASAT)	.....UI
WBC	...../mm^3	SGPT (ALAT)	.....UI
NEUTRO	.....%	GAMMA GT	.....UI
EOSINO	.....%	GLYCEMIA	.....(mmol/l)
BASO	.....%	CHOLESTEROL	.....(mmol/l)
LYMPHO	.....%	CREATININE	.....(µmol/l)
MONO	.....%	URIC ACID	.....(µmol/l)
HEMATOCRIT	.....%	TRIGLYCERIDES	.....(mmol/l)
HEMOGLOBIN	.....g	ESR (sedimentation rate)	.....

BLOOD GROUP

Test only if not already known

URINE:	Albumin	Sugar	Blood .....
STOOLS:	Parasites	Blood	

CONCLUSION:

Fit for all areas: Yes ☐ No ☐
Must be reassessed: Yes ☐ No ☐

(if you answer NO, please give details of your reasons)

Details: .....
.....
.....
.....
.....
.....

SIGNATURE

STAMP/SEAL

Date of medical examination (day/month/year) ...../...../.....

EXAMINING PHYSICIAN'S NAME AND ADDRESS:

Name..... First name.....
Street.....
City ..... Country .....
Tel ..... Fax.....
e-mail .....