

Oil & Gas UK Medical Screening Questionnaire

Documentation for Oil & Gas UK Medical booking.

Please answer all the questions below. Once you have completed the form please print and bring to your appointment.

PERSONAL DETAILS:

NAME:

LAST NAME:

AGE:

DATE OF BIRTH:

DAY:

MONTH:

YEAR:

ADDRESS:

TELEPHONE NUMBER:

EMAIL:

GP DETAILS:

GP's NAME:

GP's TELEPHONE NUMBER:

GP's ADDRESS:

EMPLOYMENT DETAILS:

OFFSHORE OCCUPATION / JOB TITLE:

DATE OF LAST OFFSHORE MEDICAL:

CURRENT EMPLOYER:

CURRENT OFFSHORE INSTALLATION:

SOCIAL / OCCUPATIONAL HISTORY:

SMOKING STATUS: YES NO

HOW MANY UNITS OF ALCOHOL YOU DRINK PER WEEK: 1 5 10 20 30 40

HAVE YOU EVER BEEN EXPOSED TO ANY KNOWN OCCUPATIONAL HAZARD SUCH NOISE,

RADIATION, DUST, ASBESTOS, CHEMICALS OR LEAD? YES NO

DO YOU USE PROTECTIVE CLOTHING? YES NO

DO YOU USE SAFETY GLASSES? YES NO

DO YOU USE HEARING PROTECTION? YES NO

HAVE YOU EVER DEVELOPED A MEDICAL CONDITION IN CONNECTION WITH
YOUR OCCUPATION? YES NO

HAVE YOU EVER SUFFERED AN INDUSTRY INJURY? YES NO

HAVE YOU EVER HAD ANY PREVIOUS AUDIOMETRIC SCREENING? YES NO

HAVE YOU EVER HAD PREVIOUS LUNG FUNCTION TESTING? YES NO

HAVE YOU EVER BEEN REJECTED FROM EMPLOYMENT ON MEDICAL GROUNDS? YES NO

HAVE YOU EVER RECEIVED COMPENSATION OR IS THERE ANY INDUSTRIAL
CLAIM PENDING? YES NO

HAVE YOU EVER BEEN MEDEVACED FROM ANOTHER OFFSHORE PLATFORM? YES NO

MEDICAL DETAILS:

DO YOU OR HAVE YOU EVER BEEN DIAGNOSED AS SUFFERING FROM ANY OF THE FOLLOWING?:

CHEST PAIN	HEART PAIN	HIGH BLOOD PRESSURE
STROKE	ASTHMA	EPILEPSY
DIABETES	PEPTIC ULCER DISEASE	KIDNEY DISEASE
PSYCHIATRIC DISORDER	TUBERCULOSIS	CANCER
ALLERGIES	NONE OF THE ABOVE	

**DO ANY OF YOUR IMMEDIATE FAMILY (PARENTS/BROTHER/SISTERS) HAVE AN HISTORY OF ANY OF THE
ABOVE CONDITIONS? YES NO**

DO YOU HAVE ANY OF THE FOLLOWING?:

BACKACHE JOINT MUSCULAR PAIN	HERNIA RUPTURE
VISUAL IMPAIRMENT	PERFORATED EARDRUM/DISCHARGE FROM EAR
RECURRENT INDIGESTION	JAUNDICE/HEPATITIS/GALLBLADDER DISEASE
CHANGE IN BOWEL HABIT/DIARRHOEA	BLOOD IN STOOL/HAEMORRHOIDS/PILES
SHORTNESS OF BREATH	COUGHING UP BLOOD
RECURRENT BRONCHITIS/PNEUMONIA	BLOOD IN URINE
KIDNEY COMPLICATIONS	STONES
HEADACHES/MIGRAINES/DIZZINESS	NONE OF THE ABOVE

ARE YOU CURRENTLY TAKING ANY MEDICATION?:

YES

NO