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* 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 DISAESE | KIDNEY DISAESE |
| PSYCHIATRICDISORDER | 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 |
| RECCURRENT BRONCHITIS/PNEUMONIA | BLOOD IN URINE |
| KIDNEY COMPLICATIONS | STONES |
| HEADACHES/MIGRAINES/DIZZINES | NONE OF THE ABOVE * |