MEDICAL IN CONFIDENCE

Medical Screening Questionnaire
Oil and Gas UK

Surname:..... Forename(s).....			
Address:..... Tel No:.....			
Date of Birth:..... Marital Status: M / C / S / D / W Offshore Occupation/Job Title:..... Employing Company:			
Date of Last Offshore Medical: ..... Date of Last Survival Course			
Fire Team Member: Yes/No			
Social History			
Do you smoke? Yes/no If so, how many per day?			
If an ex-smoker, when did you give up?			
Average weekly alcohol consumption in units: state quantity and type:			
Occupational History	**No**	**Yes**	**Comments**
1. Have you been exposed to any known occupational hazard such as noise, radiation, dusts, asbestos, chemicals or lead?			
2. Have you used protective clothing, safety glasses or hearing protection?			
3. Have you ever developed any medical condition in connection with your occupation? If so, please give details e.g. hearing loss/skin condition/ wheeze/backache/muscle strain/blood disease?			
4. Have you suffered any industrial injury? If so, please give details:			
5. Have you had any previous hearing tests? Was this normal? State when and where.			
6. Have you had previous lung function screening? Was this normal? State when and where.			
7. Have you ever been rejected from employment on medical grounds?			
8. Have you received compensation, or is there any industrial claim pending?			
9. Have you ever been evacuated for emergency medical reasons from an offshore installation?			
Physician's Comments:			

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Do you have, or have you been diagnosed as suffering from any of the following?			
	No	**Yes**	**Comments / Details**
1. Chest pain/heart pain/ heart attack			
2. High Blood Pressure			
3. Stroke			
4. Asthma			
5. Epilepsy			
6. Diabetes			
7. Peptic ulcer disease			
8. Kidney disease e.g. stones			
9. Psychiatric disorder e.g. anxiety/depression			
10. Tuberculosis			
11. Cancer			
9. Do any of your immediate family (parent/brothers/sisters) have a history of any of the above conditions? Please specify			
Do you currently have any of the following?			
1. Backache/joint or muscular pain			
2. Hernia/rupture			
3. Visual impairment, apart from wearing glasses			
4. Perforated eardrum/discharge from ear			
5. Recurrent indigestion			
6. Jaundice/hepatitis/gall bladder disease			
7. Change in bowel habit/diarrhoea			
8. Blood in stools/piles, haemorrhoids			
9. Shortness of breath/coughing up blood			
10. Recurrent bronchitis/pneumonia			
11. Blood in urine/kidney complications/stones			
12. Headaches/migraine/dizziness			
Are you on any regular medication? 13. If so please list here or bring the repeat prescription or medication with you			
14. How long ago is it since you saw the dentist?		months ago	

I certify that the above information is correct:

Signed:..... Date:.....

Name:.....