

Addendum 1

Medical Screening Questionnaire and Examination Record

Medical Screening Questionnaire and Examination Record

Surname:	Forenames:	
Address:	Tel No:	
Date of Birth:		
GP's Name:		
GP's Address:		
Date of Last Offshore Medical:	Offshore Occupation/Job Title:	
Emergency Response Role:		

Social/Occupational History	Yes	No	Comments
1. Do you smoke? If so, 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.			
8. Have you ever had any previous audiometric 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 medivaced from an offshore installation?			

Examining Physician's comments:

**Medical Screening Questionnaire and
 Examination Record (cont'd)**

Do you have or have you been diagnosed as suffering from any of the following?			
<i>(Please circle and elaborate)</i>			
1. Chest pain/heart pain	Yes	No	
2. High blood pressure/stroke	Yes	No	
3. Asthma/epilepsy/diabetes	Yes	No	
4. Peptic ulcer disease	Yes	No	
5. Kidney disease (eg stones)	Yes	No	
6. Psychiatric disorder (eg anxiety, depression)	Yes	No	
7. Tuberculosis	Yes	No	
8. Cancer	Yes	No	
Do any of your immediate family (parents/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	Yes	No	
2. Hernia/rupture	Yes	No	
3. Visual impairment	Yes	No	
4. Perforated eardrum/discharge from ear	Yes	No	
5. Recurrent indigestion	Yes	No	
6. Jaundice/hepatitis/gall bladder disease	Yes	No	
7. Change in bowel habit/diarrhoea	Yes	No	
8. Blood in stools/piles/haemorrhoids	Yes	No	
9. Shortness of breath/coughing up blood	Yes	No	
10. Recurrent bronchitis/pneumonia	Yes	No	
11. Blood in urine/kidney complications/stones	Yes	No	
12. Headaches/migraine/dizziness	Yes	No	
Physician's comments:			
I certify that the above information is correct:			
Signed:..... [Employee]			