



Medical Screening Questionnaire for Offshore Workers

First Name:	Last Name:
Tel No:	Date of Birth:
Address:	GP Address:
Date of last offshore medical:	Offshore occupation:
Operational Medical Advisor Name:	Emergency Response Role:
Medical Advisor Contact details:	

Social/Occupational History	Yes	No	Comments
Do you smoke? If so, how many per day?			
If an ex-smoker, when did you give up?			
Average weekly alcohol consumption, state quantity and type			
Have you ever been exposed to any known occupational hazards such as noise, radiation, dusts, asbestos, chemicals or lead?			
Do you use protective clothing, safety glasses or hearing protection?			
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?			
Have you ever suffered any industrial injury? If so, please give details.			
Have you ever had any previous audiometric screening? Was this normal? State when and where.			
Have you ever had previous lung function screening? Was this normal? State when and where.			
Have you ever been rejected from employment on medical grounds?			
Have you ever received compensation or is there any industrial claim pending?			
Have you ever been medivaced from an offshore installation?			

Examining Physicians Comments:

Medical Screening Questionnaire and Examination Record (cont'd)

Do you have or have you been diagnosed as suffering from any of the following?

(please circle and elaborate)

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. Psychiatry 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/gallbladder 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]