Date Age Pass / Fail

UKOOA MEDICAL QUESTIONNAIRE / EXAMINATION FORM

Date of examination ……..

PERSONAL DETAILS		
Surname:	Forename:	
Address:		Tel No.
Other Address:		Tel No.
Date of birth:	Marital status: M / S / D / W	
GP's name:	Offshore occupation / job title:	
GP's Address:		
Date of last offshore medical:	Date of last survival course:	
Fire team member:	YES / NO	

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 been exposed to any known occupational hazard such as noise, radiation, dusts, asbestos, chemicals or lead?			
5. Have you used protective clothing, safety glasses or hearing protection?			
6. Have you ever developed any medical condition connected with your occupation? If so, please give details eg. hearing loss / skin condition / backache / muscle strain / blood disease.			
7. Have you suffered any industrial injury? If so, please give details.			
8. Have you had any previous audiometric screening? Was this normal? State when and where.			
9. Have you had previous lung function screening? Was this normal? State when And where.			
10. Have you ever been rejected from employment on medical grounds, or failed an offshore medical elsewhere?			
11. Have you received compensation, or is there any industrial claim pending?			
12. Have you ever been medivaced from an offshore installation?			

EXAMINING PHYSICIAN'S COMMENTS

GENERAL MEDICAL QUESTIONNAIRE

MEDICAL HISTORY REQUIRING SPECIAL CONSIDERATION

DO YOU HAVE OR HAVE YOU BEEN DIAGNOSED AS SUFFERING FROM ANY OF THE FOLLOWING: Please circle and elaborate

1. Chest pain / heart disease	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 disease (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:			
EXAMINING PHYSICIAN'S COMMENTS			

DO YOU HAVE OR HAVE YOU HAD ANY SIGNIFICANT OR RECURRENT PROBLEMS WITH THE FOLLOWING: Please circle and elaborate

1. Backache / joint or muscular pain	YES	NO	
2. Hernia / rupture	YES	NO	
3. Visual impairment	YES	NO	
4. Perforated eardrum /ear discharge	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 stool/piles/haemorrhoids	YES	NO	
9. Shortness of breath / coughing blood	YES	NO	
10. Recurrent bronchitis/pneumonia	YES	NO	
11. Blood in urine / kidney complications / stones	YES	NO	
12. Headaches / migraine / dizziness	YES	NO	
EXAMINING PHYSICIAN'S COMMENTS			

GENERAL MEDICAL QUESTIONNAIRE

13. Varicose veins	YES	NO	
14. Skin trouble (eg. dermatitis / eczema)	YES	NO	
15. Surgical operations	YES	NO	
16. Hospitalisation	YES	NO	
17. Fear of flying / fear of heights	YES	NO	
18. Tropical illnesses/Venereal diseases /HIV	YES	NO	
19. History of alcohol / drug abuse	YES	NO	
20. Do you have any allergies? Please list	YES	NO	
21. Do you have any current illnesses? Please list	YES	NO	
22. Are you taking any medication including vitamins, anticoagulants etc. at present?	YES	NO	
23. Have you attended a dentist in the last year?	YES	NO	
24. Are you undergoing dental treatment?	YES	NO	

25. Travellers vaccinations	Date of last booster	Traveller's vaccinations	Date of last booster
Tetanus		Diphtheria	
Polio		Hepatitis A	
Typhoid		Hepatitis B	
Yellow fever		Others	

FOR FEMALES ONLY – HAVE YOU EVER HAD?

Please circle and elaborate

26. An abnormal smear / breast disease	YES	NO	
27. Gynaecological problems eg. pelvic infection	YES	NO	
28. Complications of pregnancy	YES	NO	
29. Please give date of last menstrual period			

EXAMINING PHYSICIAN'S COMMENTS

"I DECLARE THE ABOVE TO BE TRUE TO THE BEST OF MY KNOWLEDGE. I AGREE THAT THE RESULT OF MY MEDICAL EXAMINATION, INCLUDING APPROPRIATE INVESTIGATIONS CARRIED OUT IN ORDER TO ESTABLISH MY MEDICAL FITNESS MAY BE REVEALED TO A COMPANY MEDICAL OFFICER IF REQUIRED. I ACCEPT THE TRANSFER OF MY MEDICAL FILES TO OTHER DOCTORS WORKING FOR THE COMPANY IN WHICH I GAIN EMPLOYMENT."

NON DECLARATION OF SIGNIFICANT MEDICAL PROBLEMS MAY RESULT IN TERMINATION OF EMPLOYMENT.

SIGNATURE OF EMPLOYEE…….. DATE…….