CONTRACTOR MEDICAL FORMS

Medical Questionnaire / Examination Form

PERSONAL DETAILS

Surname:	Forenames:	
Address:		Tel No:
Other Address:		Tel No:
Date of Birth:	Martial 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**	**Write in answers**
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 in connection with your occupation? If so please give details *e.g. hearing loss / skin condition /wheeze / 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?			
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 *(e.g. stones)*	YES	NO	
6. Psychiatric disorder *(e.g. 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 / 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 stool / 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	
EXAMINING PHYSICIAN'S COMMENTS			

General Medical Questionnaire

13. Varicose veins	YES	NO	
14. Skin trouble *(e.g. dermatitis / eczema)*	YES	NO	
15. Surgical operations	YES	NO	
16. Hospitalisation	YES	NO	
17. Fear of flying / fear of heights	YES	NO	
18. Tropical diseases / venereal disease / HIV	YES	NO	
19. History of alcohol / drug abuse	YES	NO	
20. Do you have any allergies? Please list	YES	NO	
21. Do have any current illnesses? Please list.	YES	NO	
22. Are you receiving any medication, including vitamins, etc, at present? Please list.	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:	Travellers Vaccinations:	Date of Last Booster:
Tetanus		Diphtheria	
Polio		Hep A	
Typhoid		Hep 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 *e.g. 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 MAY GAIN EMPLOYMENT.**"**

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

SIGNATURE OF EXAMINEE:..... **DATE:** .....

Medical Examination

To Be Completed By Examining Physician

PROOF OF IDENTITY PRODUCED YES / NO

Age	Height	Weight	BMI	BP	Pulse	Peak Flow	Predicted PFR	Urinalysis		
								Protein	Blood	Glucose
								Ph		**Temp**

Vision - Distance			Vision - Near			Colour		VDU
L	Aided L	BOTH	L	Aided L	BOTH	Normal	Abnormal	
R	Aided R		R	Aided R				

	Normal	Abnormal	Elaborate On Abnormal Findings
1 EYES / PUPILS			
2 EAR, NOSE & THROAT			
3 TEETH (Date of last dental check)			
4 LUNGS / CHEST			
5 CARDIOVASCULAR			
6 ABDOMEN			
7 HERNAL ORIFICES			
8 RECTAL			
9 GENITOURINARY			
10 MUSCULOSKELTAL (Spine & Back)			
11 SKIN			
12 VARICOSE VEINS			
13 NEUROLOGICAL			
14 BREASTS			
15 IDENTIFYING MARKS (Tattoos / Scars)			

PHYSICIAN TO COMMENT ON <u>ANY</u> ABNORMALITIES

INVESTIGATIONS	Normal	Abnormal		Normal	Abnormal
1 AUDIOMETRIC SCREENING			6 CHEST X-RAY (If indicated)		
2 SUBSTANCE ABUSE SCREENING (Spec No.)			7 DENTAL CERTIFICATION (If indicated)		
3 URINALYSIS			8 ECG (If indicated)		
4 PEAK FLOW			9 STOOL CULTURE		
5 VITALOGRAPH (If indicated)			10 Blood work *		

* Blood analysis including

Blood Chemistry[1]
CBC with Differential[1]
VDRL *(Syphilis Serology)*[1]
Gamma GT and drug screening [1]
Blood Type with Rh *(If type unknown)*
G-6-PD *(P.L. Vivax areas only) (For assignments to certain countries)*
Hepatitis A Antibody Total[2] *(Endemic areas only) (if not already immune)*
TB Mantoux/PPD Test *(Unless previously positive)*
Cholesterol Profile –

Stool for Ova & Parasites and Giardia Antigen[3]
Urinalysis with Microscopic[1]

GENERAL COMMENTS

CONCLUSION

I CERTIFY THAT
…….

IS **FIT / UNFIT** FOR OFFSHORE EMPLOYMENT AND TO UNDERTAKE SURVIVAL TRAINING, IN KEEPING WITH CURRENT UKOOA HEALTH ADVISORY COMMITTEE GUIDELINES ON MEDICAL FITNESS FOR OFFSHORE WORK.

DATE OF MEDICAL …… DATE OF EXPIRY ……

SIGNED …….
Examining Physician

MEDICAL CERTIFICATE

Fit for Duty

No: .....

NAME: ..... **Date of Birth:** .....

COMPANY NAME:
.....

OCCUPATION:
.....

This employee has been examined in accordance with UKOOA Medical Guidelines, and in my opinion, is **FIT / UNFIT** for employment offshore.

.....
.....
Full Name of Examining Physician **Date of examination**

.....
.....
Signed by Physician **Date of expiry**