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 e.g. 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? *(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 (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 families (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/diarrhea	Yes	No	
8. Blood in stools/piles/hemorrhoids	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)

West Jefferson Industrial Medicine, L.L.C.

EMPLOYEE INFORMATION:

Company:_____ Facility:_____ Status: Active or Pre-Employment

SSN:_____ Employee #:_____ Hire Date:_____

Name:_____ Job Title:_____

Date of Birth:_____ Sex: Male or Female Shift: Day or Night

AAO-HNS Medical Referral Criteria – 1996:

Have you recently experienced pain in either ear?	Right – Left – Both – No
Have you recently experienced a draining ear?	Right – Left – Both – No
Have you recently experienced dizziness?	Right – Left – Both – No
Have you recently experienced severe tinnitus (ringing)?	Right – Left – Both – No
Have you recently experienced fluctuating hearing loss?	Right – Left – Both – No
Have you recently experienced sudden hearing loss?	Right – Left – Both – No
Have you recently experienced ear fullness or discomfort?	Right – Left – Both – No
Have you recently had problems wearing hearing protection?	Yes - No

Examiner Only:

(Examiner only) Subject has visible wax or object in ear.	Yes – No
(Examiner only) Subject should be referred.	Yes - No

Medical History:

Have you ever served in the military?	Yes – No
Have you ever been to a doctor for an ear related problem?	Right – Left – Both – No
Have you ever had a severe head injury?	Yes – No
Have you ever had ear surgery?	Right – Left – Both – No
Have you ever had an ear injury?	Right – Left – Both – No
Have you ever had measles?	Yes – No
Have you ever had mumps?	Yes – No
Have you ever had kidney disease?	Yes – No
Have you ever had scarlet fever?	Yes – No
Have you ever had meningitis?	Yes - No
Do you have diabetes?	Yes – No
Do you have high blood pressure?	Yes – No
Do you have an existing hearing problem?	Yes – No
Do you have frequent ear infections?	Right – Left – Both – No
Do you shoot guns of hunt?	Yes – No
Do you wear a hearing aid?	Right – Left – Both – No
Do you participate in loud activities (music, motorcycle)?	Yes – No
Do you currently us prescription of over the counter drugs?	Yes – No
Are you currently suffering from allergies?	Yes – No
Does any of your immediate family have hearing problems?	Yes – No

Do you have any other comments on the health of your hearing? _____

_____ _____

Examiner Date Subject X Date

BACK SCREENING QUESTIONAIRE

NAME: _____

SOCIAL SECURITY#_____

1) Do you have a history of back surgery? Yes or No

Explain: _____

_____

2) Do you have any weakness in your lower extremities? Yes or No

Explain: _____

_____

3) Do you have any sensory changes such as numbness/tingling in your lower extremities? Yes or No

Explain: _____

_____

4) Do you have a history of trauma involving your back? Yes or No

Explain: _____

_____

5) Do you have any problems involving your bowel or bladder? Yes or No

Explain: _____

_____

6) Do you presently have back pain? Yes or No

Explain: _____

_____

Employee Signature:_____

Physician Signature: _____

Date: _____

GRETNA LOCATION:
107 Wall Blvd. • Suite A
Gretna, Louisiana 70056
PHONE: 504.433.5070 • FAX: 504.433.5077

West Jefferson Industrial Medicine, L.L.C.
Your Company....Our Priority
www.wjimed.com

MARRERO LOCATION
4475 Westbank Expressway • Suite A
Marrero, Louisiana 70072
PHONE: 504.347.8471 • FAX: 504.340.2885

West Jefferson Industrial Medicine

Please Print:

NAME: _____ AGE: _____

ADDRESS: _____

CITY: _____ STATE _____ ZIP CODE: _____

PHONE # (_____) _____ SEX: _____

DATE OF BIRTH: _____ SOCIAL SECURITY # _____

COMPANY: _____

CONSENT FOR SERVICES

I hereby consent to medical evaluation, testing, and/or treatment to me by the staff of West Jefferson Industrial Medicine.

I authorize West Jefferson Industrial Medicine to disclose Protected Health Information necessary to carry out treatment, payment or healthcare operations.

I understand that my treatment or service may be denied by refusal to sign this consent if these services or treatment are at the request of a third party who will require disclosure of information.

I hereby release West Jefferson Industrial Medicine and its employees from any liability arising from this disclosure.

_____ _____

Signature Date

Medical Screening Questionnaire and Examination Record (cont'd)

Medical Examination

To be completed by Examining Physician

Photographic ID:	Passport:
	Driver's license number:
	Other:

Height	**Weight**	**BMI**	**BP**	**Pulse**	**FEV_1**	**FVC**	**FEV_1/FVC**	**Urinalysis**		
								Protein	**Blood**	**Glucose**

Vision – Distance			**Vision – Near**			**Color**		**VDU**
L	Aided L	Both	L	Aided L	Both	Normal	Abnormal	
R	Aided R		R	Aided R				

	N	**A**	**Comment**
Audiometric Screening			
Substance Abuse Screening			
Stool Culture (Catering Crew)			

Medical Screening Questionnaire and Examination Record (cont'd)

	Normal	Abnormal	Comments
1. Eyes/Pupils			
2. Ear, Nose and Throat			
3. Teeth			
4. Lungs/Chest			
5. Cardiovascular			
6. Abdomen			
7. Hernial Orifices			
8. Genitourinary			
9. Musculoskeletal			
10. Skin			
11. Varicose Veins			
12. Neurological			
Physician to comment on any abnormalities:			

Certification	Comment/Reason
Fit for offshore work as per Oil & Gas UK guidelines	
Fit for restricted offshore work following discussion with operating company's medical advisor	
Temporarily unfit for offshore work	
Permanently unfit for offshore work	

Physician Signature: .....

Print Name: ....Brian Bourgeois, MD.....

Date of examination: .....

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www.wjimed.com

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MARRERO LOCATION
4475 Westbank Expressway • Suite A
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PHONE: 504.347.8471 • FAX: 504.340.2885

Medical Certificate of Fitness for Offshore Work

(Issued in accordance with Oil and Gas UK Guidelines)

Name:	
Date of Birth:	
Employing Company Name:	
Occupation:	

This individual has been examined in accordance with Oil & Gas UK Guidelines and is **Medically Fit for Unrestricted Offshore Work.**

Examining Physician Name:	Brian Bourgeois, MD
Oil & Gas UK Pin No:	UKOOA 942 2006
Date of Examination:	
Date of Expiry of Certificate:	
Signed:	

UKOOA

Oil and Gas for Britain

UKOOA MEDICAL EXAMINATION

Employee Name: _____ Physician Name: BRIAN BOURGEOIS M.D

Date of Examination: _____ Expiration Date: _____

Age: _____ Age Group: <20
(Circle) 20-29
30-39
40-49
50-59
60+

Outcome: PASS
(Circle) FAIL
RESTRICT

Reason for Fail or Restrict

THIS FORM IS FOR THE USE OF THE EXAMINING PHYSICIAN ONLY AND SHOULD NOT BE SENT TO UKOOA AS PART OF THE ANNUAL RETURN