Medical Screening Questionnaire and

Examination Record

Surname:	Forenames:
Address:	Tel No:
Date of Birth:	
General Practitioners Name:	
General Practitioners 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?	☐	☐	

Medical Screening Questionnaire and Examination Record (cont'd)

Do you have or have you been diagnosed as suffering from any of the following? *(please mark yes or no and elaborate)*	**Yes**	No	**Comments**
1. Chest pain/heart pain	☐	☐	
2. High blood pressure/stroke	☐	☐	
3. asthma/epilepsy/diabetes	☐	☐	
4. Peptic ulcer disease	☐	☐	
5. Kidney disease (e.g. stones)	☐	☐	
6. Psychiatric disorder (e.g. anxiety, depression)	☐	☐	
7. Tuberculosis	☐	☐	
8. Cancer	☐	☐	
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?	**Yes**	**No**	**Comments**
1. Backache/joint or muscular pain	☐	☐	
2. Hernia/rupture	☐	☐	
3. Visual impairment	☐	☐	
4. Perforated eardrum/discharge from ear	☐	☐	
5. Recurrent indigestion	☐	☐	
6. Jaundice/hepatitis/gall bladder disease	☐	☐	
7. Change in bowel habit/diarrhea	☐	☐	
8. Blood in stools/piles/hemorrhoids	☐	☐	
9. Shortness of breath/coughing up blood	☐	☐	
10. Recurrent bronchitis/pneumonia	☐	☐	
11. Blood in urine/kidney complications/stones	☐	☐	
12 Headaches/migraine/dizziness	☐	☐	

I certify that the above information is correct:

Signed: **(Employee)**

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

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

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

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 the 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? _____

Subject X _____ Date _____

Gretna Clinic
107 Wall Blvd.
Gretna, LA 70056
504-433-5070

Back Screening Questionaire
West Jefferson Industrial Medicine

Marrero Clinic
4475 Westbank Expy.
Marrero, LA 70072
504-347-8471

Date: _____

Patient Name: _____

Social Security Number: _____

1. Do you have a history of back surgery? ☐ YES ☐ NO

Explain: _____

_____

2. Do you have any weakness in your lower extremities? ☐ YES ☐ NO

Explain: _____

_____

3. Do you have any sensory changes such as numbness/tingling in your lower extremities? ☐ YES ☐ NO

Explain: _____

_____

4. Do you have a history of trauma involving your back? ☐ YES ☐ NO

Explain: _____

_____

5. Do you have any problems involving your bowel or bladder? ☐ YES ☐ NO

Explain: _____

_____

6. Do you presently have back pain? ☐ YES ☐ NO

Explain: _____

_____

_____
Employee Signature

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Gretna, Louisiana 70056
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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 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