Just-Health
Health Check HGV TAXI LGC PCV D4 DVLA PRIVATE MEDICALS BUS AMBULANCE

Oil & Gas UK Medical Screening Questionnaire

Please answer all the questions below. Once you have completed the form please print and bring to your appointment.

PERSONAL DETAILS:

NAME:

LAST NAME:

AGE:

DATE OF BIRTH:

DAY: **MONTH:** **YEAR:**

ADDRESS:

TELEPHONE NUMBER:

EMAIL:

GP DETAILS:

GP's NAME:

GP's TELEPHONE NUMBER:

GP'sADDRESS:

EMPLOYMENT DETAILS:

OFFSHORE OCCUPATION / JOB TITLE:

DATE OF LAST OFFSHORE MEDICAL:

CURRENT EMPLOYER:

CURRENT OFFSHORE INSTALLATION:

SOCIAL / OCCUPATIONAL HISTORY:

SMOKING STATUS: **YES** **NO**

HOW MANY UNITS OF ALCOHOL YOU DRINK PER WEEK: **1** **5** **10** **20** **30** **40**

HAVE YOE EVER BEEN EXPOSED TO ANY KNOWN OCCUPATIONAL HAZARD SUCH NOISE, RADIATION, DUST, ASBESTOS, CHEMICALS OR LEAD? **YES** **NO**

DO YOU USE PROTECTIVE CLOTHING? **YES** **NO**

DO YOU USE SAFETY GLASSES? YES NO

DO YOU USE HEARING PROTECTION? YES NO

HAVE YOU EVER DEVELOPED A MEDICAL CONDITION IN CONNECTION WITH YOUR OCCUPATION? YES NO

HAVE YOU EVER SUFFERED AN INDUSTRY INJURY? YES NO

HAVE YOU EVER HAD ANY PREVIOUS AUDIOMETRIC SCREENING? YES NO

HAVE YOU EVER HAD PREVIOUS LUNG FUNCTION TESTING? YES NO

HAVE YOU EVER BEEN REJECTED FROM EMPLOYMENT ON MEDICAL GROUNDS? YES NO

HAVE YOU EVER RECEIVED COMPENSATION OR IS THERE ANY INDUSTRIAL CLAIM PENDING? YES NO

HAVE YOU EVER BEEN MEDEVACED FROM ANOTHER OFFSHORE PLATFORM? YES NO

MEDICAL DETAILS:

DO YOU OR HAVE YOU EVER BEEN DIAGNOSED AS SUFFERING FROM ANY OF THE FOLLOWING?:

CHEST PAIN	HEART PAIN	HIGH BLOOD PRESSURE
STROKE	ASTHMA	EPILEPSY
DIABETES	PEPTIC ULCER DISAESE	KIDNEY DISAESE
PSYCHIATRICDISORDER	TUBERCULOSIS	CANCER
ALLERGIES	NONE OF THE ABOVE	

DO ANY OF YOUR IMMEDIATE FAMILY (PARENTS/BROTHER/SISTERS) HAVE AN HISTORY OF ANY OF THE ABOVE CONDITIONS? YES NO

DO YOU HAVE ANY OF THE FOLLOWING?:

BACKACHE JOINT MUSCULAR PAIN	HERNIA RUPTURE
VISUAL IMPAIRMENT	PERFORATED EARDRUM/DISCHARGE FROM EAR
RECURRENT INDIGESTION	JAUNDICE/HEPATITIS/GALLBLADDER DISEASE
CHANGE IN BOWEL HABIT/DIARRHOEA	BLOOD IN STOOL/HAEMORRHOIDS/PILES
SHORTNESS OF BREATH	COUGHING UP BLOOD
RECCURRENT BRONCHITIS/PNEUMONIA	BLOOD IN URINE

KIDNEY COMPLICATIONS	**STONES**
HEADACHES/MIGRAINES/DIZZINES	**NONE OF THE ABOVE**

ARE YOU CURRENTLY TAKING ANY MEDICATION?: