Regent Street Clinic

Medical Screening Questionnaire and examination record

Surname:	Forename:
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 medevaced from an offshore installation?	☐	☐	

Examining physicians 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. Astma / Epilepsy / Diabetes	**Yes**	**No**	
4. Peptic Ulcer Diseases	**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;

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. Changes in bowel habit / diaorrea	**Yes**	**No**	
8. Blood in stools / piles / Haemorrhoids	**Yes**	**No**	
9. Shortness of breath / coughing up blood	**Yes**	**No**	
10. Recruitment bronchitis	**Yes**	**No**	
11. Blood in urine / kidney complications / stones	**Yes**	**No**	
12. Headache / migraine / dizziness	**Yes**	**No**	

Physicians comments:

I certify that the above information is correct:

Signed ..... (Employee)

Medical Screening Questionnaire and examination record *(cont'd)*

Medical Examination

To be completed by Examining Physician

Photographic ID:	Passport:	
	Drivers licence number:	
	Other:	

Height	Weight	BMI	BP	Pulse	FEV,	FVC	FEV,/ FVC	Urinalysis		
								Protein	Blood	Glucose

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

	N	A	
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 adviser	
Temporary unfit for offshore work	
Permanently unfit for offshore work	

Physicians Signature .....

Date of examination:

Print Name: