Templar MEDICAL
T: 01547 530967 M: 07979 755631
E: enquiries@templarmedical.co.uk

RUK Medical Screening Questionnaire and Examination Record

Surname:	**Forenames:**
Address:	**Tel No:** **Mobile:**
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 hazards such as noise, radiations, 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:			

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RUK Medical Screening Questionnaire and Examination Record (cont.)

Do you have or have you been diagnosed as suffering 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 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. Change in bowel habit/diarrhoea	**Yes**	**No**	
8. Blood in stools/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**	

Physician's Comments:

I certify that the above information is correct:

Signed:…… **Date:**……/……../……

Print Name:……