NOGEPA
Netherlands Oil and Gas Exploration and Production Association

EXAMINATION FORM - QUESTIONNAIRE

PERSONAL DETAILS

Family name: Christian name:

Address:

Tel No:

Other Address:

Tel No:

Date of Birth:

Marital Status: M / S / D / W

GP's Name:

GP's Address:

Offshore Occupation/Job Title:

Date of Last Offshore Medical:

Date of Last Survival Course:

Fire Team Member: Yes/No (circle)

SOCIAL/OCCUPATIONAL HISTORY

Write in answers

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 been exposed to any known occupational hazard *such as noise, radiation, dusts, asbestos, chemicals or lead?*

5. Have you used 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 suffered any industrial injury? If so please give details:

8. Have you had any previous audiometric screening? Was this norma1?
State when and where.

9. Have you 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 received compensation, or is there any industrial claim pending?

12. Have you ever been medivaced from an offshore installation?

EXAMINING PHYSICIAN'S COMMENTS

MEDICAL HISTORY REQUIRING SPECIAL CONSIDERATION
DO YOU HAVE OR HAVE YOU BEEN DIAGNOSED AS SUFFERING FROM ANY OF THE FOLLOWING? Please circle and elaborate

1. Chest pain/ heart disease YES *NO*

2. High blood pressure 1 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,* YES *NO 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:

EXAMINING PHYSICIAN'S COMMENTS

DO YOU HAVE OR HAVE YOU HAD ANY SIGNIFICANT OR RECURRENT PROBLEMS WITH THE FOLLOWING? Please circle and elaborate

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. Do you have a regular dentist? Details (name, address, etc)

• When was your last visit?

• What was this for? Do you have more appointments?

• Do you have any toothache?
• Do your teeth ache after eating and drinking?

• Do your gums bleed spontaneously or after brushing?

• Do you wear false teeth?

6. Recurrent indigestion YES *NO*

7. Jaundice / hepatitis / gall bladder disease YES *NO*

8. Change in bowel habit / diarrhoea YES *NO*

9. Blood in stool / piles, haemorrhoids YES *NO*

10. Shortness of breath / coughing up blood YES *NO*

11. Recurrent bronchitis / pneumonia YES *NO*

12. Blood in urine / kidney complications YES *NO* stones YES *NO*

13. Headaches / migraine 1 dizziness YES *NO*

14. Varicose veins YES *NO*

15. Skin trouble *(e.g. dermatitis / eczema)* YES *NO*

16. Surgical operations YES *NO*

17. Hospitalisation YES *NO*

18. Fear of flying / fear of heights YES *NO*

19. Tropical diseases / venereal disease YES *NO*

20. History of alcohol / drug abuse YES *NO*

21. Do you have any allergies? Please list YES *NO*

22. Do have any current illnesses? Please list YES *NO*

23. Are you receiving any medication, including vitamins, etc, at present? YES *NO*
Please list

24. Travellers Vaccinations: Date of Last Booster:

Tetanus Diphtheria

Polio Hep A

Typhoid Hep B

Yellow Fever Others

FOR FEMALES ONLY - HAVE YOU EVER HAD?
Please circle and elaborate

25. An abnormal smear / breast disease YES *NO*

26. Gynaecological problems *e.g. pelvic infection* YES *NO*

27. Complications of Pregnancy YES *NO*

28. Please give date of last menstrual period

EXAMINING PHYSICIAN'S COMMENTS
"I declare the above to be true to the best of my knowledge. I agree the result of my medical examination, including appropriate investigations carried out in order to establish medical fitness may be revealed to a company medical officer if required. I accept the transfer of my medical files to either doctors working for the company in which I may gain employment"
Non-declaration of significant medical problems may result in termination of employment.

Signature of examinee: .....

Date: .....