General Health Questionnaire

MEDICAL IN CONFIDENCE

Surname	Forenames	Sex	Date of birth	Nationality

Home address	Telephone number

Company requesting medical	Company address (if known)
Occupation / Job Title	**Emergency Response Team Role / DMT (if applicable)**

General practitioner's address and telephone number

Is this medical:	1. An initial? ☐	2. A renewal? ☐			

If this is your first medical with us - give full details
If this is not your first medical with us - list any changes since your last medical

Social / Occupational History	Yes	No	Please detail
Have you ever been exposed to any known occupation hazard such as noise, radiation, vibration, dusts, asbestos, chemicals, lead or any other hazards?	☐	☐	
Do you use protective clothing, safety glasses or hearing protection?	☐	☐	
Have you ever developed any medical condition in connection with your occupation?	☐	☐	
Have you ever had to leave any employment for medical reasons?	☐	☐	
Have you ever failed or been refused an offshore medical certificate?	☐	☐	
Have you every suffered any industrial injury?	☐	☐	
Do you consider yourself to be disabled in any way?	☐	☐	
Have you ever been medevaced from an offshore installation?	☐	☐	
Daily tobacco consumption/ date stopped smoking			

Medical History: *If previously reported and no change since last medical, please write "**no change**"*

Average weekly alcohol consumption

Do you have or have you ever suffered from any of the following:	Yes	No	If Yes please detail
Vision impairment	☐	☐	
Hearing difficulty	☐	☐	
Kidney / urine complications	☐	☐	
Liver disorders	☐	☐	
Diabetes	☐	☐	
Bowel disease or persistent diarrhoeal illness	☐	☐	
Asthma / bronchitis / chronic cough / shortness of breath	☐	☐	
Dermatitis, eczema or any other skin disorder	☐	☐	
Headaches / migraine / dizziness	☐	☐	
Head injury / concussion	☐	☐	
Epilepsy / fits	☐	☐	
Neurological condition (e.g. M.S., aneurysm, brain tumour)	☐	☐	

HILVERMED BV

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Medical History *continued*

Do you have or have you ever suffered from any of the following:	Yes	No	If Yes please detail
Backache / joint or muscular pain	☐	☐	
Back condition requiring time off work or treatment by a physiotherapist, chiropractor or osteopath	☐	☐	
Rheumatism or arthritis	☐	☐	
Anxiety / depression / stress / emotional or any other psychiatric disorders	☐	☐	
High blood pressure	☐	☐	
Heart attack / stroke / angina or any other heart condition	☐	☐	
Malignant disease	☐	☐	
Dental problems	☐	☐	
Any form of drug dependence	☐	☐	
Any other health problems not covered above	☐	☐	

Are you presently receiving care (regular appointments with your GP or a hospital specialist) for an ongoing medical condition? **Yes** ☐ **No** ☐
If **Yes**, please provide details:

Are you taking any medication (prescribed or bought over the counter)? **Yes** ☐ **No** ☐
If **Yes**, please provide details:

Have you ever been admitted to hospital, undergone surgery or suffered from a serious illness? **Yes** ☐ **No** ☐
If **Yes** please provide details:

Declaration	**Yes**	**No**
I certify that the above information is correct and that I have not withheld any relevant information.	☐	☐
I agree to undergo any physical examination or test, which may be deemed appropriate by the medical staff. The nature and purpose of these will be explained to me.	☐	☐
I authorise the release of medical information for this assessment to my GP if necessary.	☐	☐

Print Name ______________ Signature ______________ Date ______________

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