قطر للطاقة QatarEnergy	**MEDICAL EXAMINATION FORM OFFSHORE CONTRACTOR PERSONNEL OCCUPATIONAL HEALTH**	**IP-MS-001 REG.NO. DATE:**

SECTION A - HEALTH SCREENING QUESTIONNAIRE

1. PERSONAL DETAILS: To be completed by the examinee or company representative

Full name:		Gender: ☐M ☐F
Nationality:	Date of Birth:	ID No.:
Job Title:		
Company Name:		
Sponsor Dept:		
Home Address:		
Mobile:	Email:	
Supervisor Name:		Mobile:
Your Doctor Name: Phone No.:		
Date of previous offshore medical:	Date of T- BOSIET Course:	

2. SOCIAL/OCCUPATIONAL HISTORY: To be completed by the examinee, seek assistance from medical staff if required

Do you smoke? ☐Yes ☐No If an ex-smoker, when did you give up? If yes how many per day?
Do you drink alcohol? ☐Yes ☐No. If yes mention weekly consumption.
Have you ever been exposed to below mentioned occupational hazard? (Tick as appropriate) ☐Noise ☐Radiation ☐Dusts ☐Asbestos ☐Chemicals ☐Lead
Have you ever developed any medical condition due to your occupation? ☐Yes ☐No If yes (Tick as appropriate) ☐Hearing Loss ☐Skin condition ☐Wheeze ☐Backache ☐Muscle strain ☐Blood diseases
Have you ever suffered any industrial injury? If yes give details below:
Have you had any previous audiometric screening? ☐Yes ☐No If yes was it normal? ☐Yes ☐No
Have you had previous lung function test? ☐Yes ☐No If yes was it normal? ☐Yes ☐No
Have you ever been rejected from employment on medical grounds? ☐Yes ☐No
Have you ever been medically evacuated from worksite? ☐Yes ☐No

3. MEDICAL HISTORY: To be completed by the examinee, seek assistance from medical staff if required

Do you have or had below health conditions	No	Yes	(Tick as appropriate, if yes give details)
Chest pain/Heart disease	☐	☐	
High Blood pressure	☐	☐	
Diabetes	☐	☐	
High Cholesterol	☐	☐	
Asthma	☐	☐	
Epilepsy	☐	☐	
Peptic ulcer disease	☐	☐	
Any Kidney problem	☐	☐	
Any Psychiatric problem	☐	☐	
Tuberculosis	☐	☐	
Any type of cancer / tumor	☐	☐	
Backache / joint or muscular pain	☐	☐	
Hernia	☐	☐	
Visual impairment	☐	☐	
Perforated ear/ discharge	☐	☐	

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Do you have or had below health conditions	No	Yes	(Tick as appropriate, if yes give details)
Recurrent indigestion	☐	☐	
Jaundice /Gall stones	☐	☐	
Any type of Hepatitis	☐	☐	
Change in bowel habit / diarrhoea	☐	☐	
Blood in stool / piles, hemorrhoids	☐	☐	
Shortness of breath	☐	☐	
Recurrent bronchitis / pneumonia	☐	☐	
Chronic cough	☐	☐	
Headaches / migraine / dizziness	☐	☐	
Varicose veins	☐	☐	
Any skin problem	☐	☐	
Any type of surgery	☐	☐	
Any hospitalization in past 10 yrs.	☐	☐	
Fear of flying / heights / water	☐	☐	
Any infectious diseases (e.g., Covid)	☐	☐	
Do you have any allergies	☐	☐	
Any current illnesses	☐	☐	
Are you on any medication	☐	☐	
Undergoing dental treatment	☐	☐	
Any dizziness / loss of consciousness	☐	☐	

If you have / had any other medical condition not listed above? Please provide details below:

4. VACCINATION RECORDS: To be completed by the examinee, seek assistance from medical staff if required

(Tick as appropriate)	Yes	No	Date	(Tick as appropriate)	Yes	No	Date
Tetanus	☐	☐		Hep A	☐	☐	
Diphtheria	☐	☐		Hep B	☐	☐	
Varicella	☐	☐		Yellow Fever	☐	☐	
Typhoid	☐	☐		BCG	☐	☐	
Covid	☐	☐	Dates	☐1st Dose	☐2nd Dose		☐3rd Dose
Other:							

5. CONSENT & DECLARATION: To be completed by the examinee

I hereby certify that personal health declaration above is true to the best of my knowledge. I hereby authorize the release of all my medical records to QatarEnergy / my employer / MOPH, examining / authorized physician in order to establish my fitness to work in an offshore environment. I am aware that offshore medical fitness card will not be issued in case of non-declaration of any known medical problem.

Date: **Signature of Examinee**

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SECTION B - CLINICAL ASSESSMENT

6. NURSING ASSESSMENT: To be completed by designated nursing staff

Height(cm)	Weight(kg)	BMI	Pulse(min)	BP (Take 2nd reading if high)	BP (2nd reading)

Distant Vision			Near Vision			Speech Discrimination		Colour Vision
	Uncorrected	Corrected		Uncorrected	Corrected	Right ear	Left ear	
R eye			R			☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal safe ☐ Abnormal unsafe
L eye			L					

7. PHYSICIAN ASSESSMENT: To be completed by the examining Physician.

Comprehensive review of Health questionnaire is advised prior to clinical assessment. Any medical or surgical history must be elaborated below. For systemic examination, please mention (N) if Normal or (AB) if Abnormal. If abnormal, provide relevant details.

General		
Eyes		
ENT		
Oral cavity		
Teeth		
Lungs/Chest		
Cardiovascular		
Abdomen		
Hernial Orifices		
Genitourinary		
Musculoskeletal		
Skin		
Blood disorders		
Neurological		
Endocrinological		
Metabolic		
Cancer / Tumor		
Infectious Dis.		

8. INVESTIGATIONS: Please mention (N) if Normal, (AB) if Abnormal or (NR) if Not Required. If abnormal, provide details.

Chest Xray		
ECG		
Spirometry		
Audiometry		
VO_2 max		

9. LAB RESULTS: Any abnormal laboratory result, please mention below and comment.

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10. HEALTH MONITORING AND MEDICAL SURVEILLANCE (√ as appropriate)

☐ Obesity	☐ Respiratory Dis.	☐ Liver Disorder	☐ Neoplasm
☐ Dyslipidaemia	☐ Abnormal ECG	☐ Kidney Disorder	☐ Mental Disorder
☐ Impaired FBS	☐ Cardiovascular Dis.	☐ Infectious Disease	☐ Hearing Conservation
☐ Diabetes	☐ Hyperuricemia	☐ Vision Correction	☐ Skin Disorder
☐ Elevated BP	☐ Hypothyroidism	☐ Fatty liver	☐ Anemia
☐ Hypertension	☐ Hyperthyroidism	☐ Asthma	☐ Not Applicable
☐ Others			

SECTION C - FITNESS TO WORK CERTIFICATE

This certificate is invalid without candidate's photograph, examining physicians' signature, and official stamp.

Name		Attach a recent passport size photograph
Date of Birth		
Qatar ID No.		
Nationality		
Company		
Job title		

Above mentioned individual has been examined in accordance with QatarEnergy Offshore medical fitness guidelines and is declared:

☐ **Fit for offshore work**
☐ **Fit for offshore work with medical surveillance**
☐ **Temporarily unfit for offshore work, review date:**

This certificate is valid from	to

Examining Physician Name:	
Designation:	
Practice license No.:	
Licensing organization:	
Medical center address:	
Email:	

Examining Physician Signature and Stamp