flyingmedicine.uk
Aeromedical Solutions

Surname Name:		First Name:			
ID supplied	Passport/ Driving License/ Other photo ID	Age:		Gender:	
Patient summary supplied	Yes / No	Date of Birth:	Day	Month	Year
Job Title					
Emergency response role? Yes/ No	Crane operator? Yes/ No	May work on normally-unmanned-installation (NUI)? Yes/ No	Catering role? Yes/ No		
Home Address:		Safety Sensitive	Yes/ No		
GP Name and Address		Postcode			

Please answer the following questions clearly and honestly. If unsure as the doctor for advice.

Have you **ever** had:	No	Yes	Additional information/ details
Been exposed to any known occupational hazard such as noise, radiation, dusts, asbestos, chemicals or lead?			
Developed any medical condition in connection with your occupation? E.g. hearing loss/ dermatitis/ wheeze/ backache/ muscle strain/ blood disease?			
Suffered an industrial injury?			
Do you use protective clothing, safety glasses or hearing protection for work?			
Ever had an audiometric screening? When, where and why?			
Ever had a previous lung function test? When, where and why?			
Ever been rejected for employment on medical grounds?			
Ever received compensation or is there an industrial claim pending?			
Ever been medevaced from an offshore installation?			
Frequent or severe headaches / migraines			
Head injury or Concussion			
Dizziness, Faints or Blackouts			
Fits, Convulsions or Epilepsy			
Depression			
Anxiety			
Bipolar			
Psychotic Mental Illness			
Any other mental illness			
Asthma			
Emphysema			
Tuberculosis (TB)			
Bronchitis			
Pneumothorax			
Any other lung complaint			
Previous Heart Attack			
Angina			
Pacemaker			
Implantable Heart Defibrillator			
Exercise ECG (Treadmill test)			
Stroke, Mini stroke, TIA, CVA			
High blood pressure			
Low blood pressure			
Any other heart complaints of any kind			
Kidney or bladder diseases e.g. ***stones***			
Prostate problems			
Urine problems e.g. frequency or urgency			
Blood in the urine			
Diabetes- Diet controlled			
Diabetes- Tablet controlled			
Diabetes- Insulin controlled			
Thyroid disease			
Other Endocrine / Hormone problems			

Have you ever been or had	No	Yes	Additional information/ details
Diagnosed with sleep apnoea or sleep disordered breathing			
Hearing problems			
Diagnosed Hearing Loss			
Need hearing aids			
Perforated ear drum or ear discharge			
Problems with digestion			
Stomach ulcers			
Jaundice			
Liver problems			
Gallstones			
Pancreatitis			
Persistent Diarrhoea			
Blood in the stools			
Hemorrhoids			
Joint problems			
Joint replacements			
Limb prosthesis			
Muscle problems			
Hernias			
Back trouble / pain e.g. Lumbago, Sciatica or Slipped disc			
Do you have pain if you sit for long periods?			
Any Rheumatology problems			
Any problems with co-ordination			
Multiple Sclerosis			
Growths, tumours or malignancies			
Skin problems e.g. eczema/ psoriasis			
Dermatitis			
HIV			
AIDS			
Hepatitis B			
Allergy requiring hospital admissions or the use of EpiPens			
Any illness not mentioned above			
Any hospital admissions overnight ever from the time of your birth?			
Sustained any serious injury, e.g. fracture or dislocation, resulting in ongoing problems			
Do you have any learning disabilities e.g. Dyslexia			
Do you have any Disabilities			
Do you have or have you ever been told you have reduced colour vision or colour blindness			
Do you wear varifocals for near and distant vision			
Do you have vision in one eye only			
Do you have issues with night time vision			
Do you take Warfarin or other blood thinning medications			
Do you take sleep medications			
Do you take medication which can affect your immune system			
Do you take **any** other prescribed medications			
Do you take **any** over the counter medications			
Do you take supplements or vitamins			
Do you take herbal medications			
Have you ever smoked- when did you quit			
Do you currently smoke, even occasionally			
Do you consume any alcohol			
How many units on average per week do you consume (1 pint =2 units, 1 small wine=1 unit, 1 small shot =1 unit)			
Do you have or has anyone suspected you have Alcoholism or Alcohol Misuse Disorder			
Do you have or has anyone suspected you have a Drug Addiction or Drug Misuse Disorder			
Have you ever been charged with an offence relating to drugs or alcohol?			
Do you exercise outside work			

MEDICAL CONSENT FORM for Medical Assessments

Please tick agreement as appropriate:

□ I hereby give my informed consent to undergo a medical examination (including substance abuse testing if required) and to the disclosure of the results and outcomes of such an examination to the relevant authorised body as needed.

I require / do not require a chaperone for the clinical examination

□ I confirm I give my permission for FlyingMedicine™ Ltd to send my reports / receipts electronically (e-mail) and or in hard copy to myself/ employers and or the relevant bodies as directed.

□ I confirm that I will FULLY disclose ALL my past and current medical information on the relevant forms and to the examiner and understand that failure to be honest, full and complete with my statements can lead the authorities to seek further action including possible criminal convictions.

□ I confirm I give my informed consent for FlyingMedicine™ Ltd to request copies of my medical records from my primary health doctors in order to complete my medical process

□ I agree that FlyingMedicine™ Ltd will not be held liable for ANY costs incurred should relevant medical standards not be met.

□ I accept that FlyingMedicine™ Ltd and the examining doctor will not be held liable for the costs of any further, additional reports, investigations, tests, specialist consultations and or downtime from work that is necessary to attain the medical standards/ reports/ certificates and that I will therefore remain solely liable for ALL additional costs incurred.

□ I am aware that there is an appeals process via the relevant authority

□ I confirm I have carefully read the above statements and sought clarification where necessary

Name:

Date of Birth:

Signature:

Date: