Medical assessment questionnaire

This medical assessment questionnaire is not a statutory document. It is for use as a template when passengers, or others who are not subject to a statutory medical examination, travel on board the vessel.

The information imparted here will only be used in an emergency, and in the best interests of the person. If possible, consent from the person will be sought prior to passing the information on to a third party. The information will be kept secure, and destroyed once the requirement to hold it ceases.

Medical assessment questionnaire

Confidential

Section 1 To be completed by the person being assessed

Name		
Date of birth (dd/mm/yyyy)		
Home address		
Contact telephone number		
Email address		
Personal doctor and contact details		
Past medical history Please record details of any medical conditions from which you suffer (continue on the back of this sheet if necessary)		
Specific conditions (delete as appropriate)	High blood pressure	Yes/No
	Angina	Yes/No
	Heart attacks (myocardial infarctions)	Yes/No
	Strokes (cerebrovascular accident)	Yes/No
	Jaundice	Yes/No
	Tuberculosis	Yes/No
	Rheumatic fever	Yes/No
	Diabetes	Yes/No
	Epilepsy	Yes/No

	Asthma	Yes/No
	Depression/ other mental illness	Yes/No
	Blood infections (such as Hepatitis A, B or C, HIV or AIDS)	Yes/No
	Chronic back pain	Yes/No
	Kidney stones	Yes/No
	Cartilage/ligament injuries	Yes/No
	Musculoskeletal injuries	Yes/No
	Indigestion/reflux	Yes/No
If you answered Yes to any of the above, record details here		
Have you had any surgical operations? *Include details and dates*		
Are there any inherited medical conditions in your family? *Include details*		
Have you received medical advice or treatment during the previous 12 months relating to any illness, disability or condition whatsoever? *If yes, please detail*		
Please record any medications that you take, either regularly, occasionally or in the past (include herbal or alternative medicines)		
Are you allergic to anything? *Include details of circumstances and reactions*		
Do you smoke? If so, number per day		
Do you drink alcohol? If so, units per week		

Please detail all immunisations/vaccinations you have had, with dates *Continue overleaf if necessary*	
What is your height (m)?	
What is your weight (kg)?	
What is your blood group?	

I certify that, to the best of my knowledge, the above information is correct.

Signature…… Date (dd/mm/yyyy)……..

Section 2 Medical examination to be completed by the Medical Practitioner

Overall appearance			
Pulse (bpm)		BMI	
Blood pressure (mmHg)		Pulse oximeter (air)	
Temperature (mouth/ear)		Blood Group	
Urinalysis result			
Cardiovascular system			
Respiratory system			
Abdominal system			
Musculoskeletal system			
Medical practitioner's name			
Address			

I certify that the information and particulars relating to…… are true and correct to the best of my knowledge.

Signature of medical practitioner	
Date (dd/mm/yyyy)	

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