

**MEDICAL REPORT**

<b>Please fill up details below</b>								
Full Name (Please underline Surname)					Date of Birth (dd/mm/yy)		Nationality	
Prospective Job (For Employee)		(For Employee) Office-based job (Yes/No)  Offshore-based job (Yes/No)		Employing Company (For Employee)		Passport Number:		
<input type="checkbox"/> Male	<input type="checkbox"/> Single	<input type="checkbox"/> Widow(er)	Relationship to Employee (for dependent)			No. of Children		
<input type="checkbox"/> Female	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced/Separated	<input type="checkbox"/> Spouse	<input type="checkbox"/> Son	<input type="checkbox"/> Daughter			
Address in country of origin:				Name and Address of Family Doctor:				
Tel. No.				Tel. No.				
<b>Previous Medical History</b> - All important medical events must be listed and dated at every medical examination. To be completed together with the interviewing Nurse or Doctor who will be able to help by referring to your notes.								
Are you a Registered Disabled Person?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Medical Insurance?		BUPA <input type="checkbox"/>	CIGNA <input type="checkbox"/>	Other <input type="checkbox"/>
<b>Please answer the following questions and tick 'N' (no) or 'Y' (yes) in the column. If 'Y', please describe</b>								
				N	Y	Description		
1. Are you currently receiving any medical treatment? Are you currently taking any medication for an illness or injury, or have you done so in the past? If yes, please describe the condition and list the medicine.								
2. Do you smoke? If yes, what and how much each day?								
3. Are you doing regular sports or physical activities?								
4. Have you ever had, or been told by a doctor that you had any of the following?				N	Y	Description		
4.1. High Blood pressure								
4.2. Ear, nose, eye or throat problems								
4.3. Double vision, difficulty seeing, Colour blindness								
4.4. Hearing loss or deafness or had an ear operation or use a hearing aid								
4.5. Do you have difficulty hearing people on the telephone (including use of hearing aid if worn)?								
4.6. Head injury, spinal injury								
4.7. Chest problems like asthma, bronchitis								
4.8. Heart abnormality / heart disease, chest pains or Angina								
4.9. Palpitations/irregular heartbeat								
4.10. Abnormal shortness of breath								
4.11. Any condition requiring heart surgery								
4.12. Abdominal pains, abnormal bowel motions								
4.13. Urogenital problems (kidney disease, menstrual disorder)								
4.14. Musculo-skeletal diseases								
4.15. Neck, back or limb disorders								
4.16. Skin trouble or allergies								
4.17. Epileptic fits, Seizures, convulsions, dizzy spells or migraine								

<b>Full Name</b> (Please underline Surname)	<b>DOB:</b>
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	N	Y	Description
4.18. Diabetes, anaemia, blood disorders			
4.19. Blackouts, fainting			
4.20. Stroke			
4.21. Dizziness, vertigo, problems with balance			
5. Have you ever had, or been told by a doctor that you had a psychiatric illness, or nervous disorder?			
6. Have you ever had any other serious injury, illness, operation, or been in hospital for any reason?			
7. Have you ever had, or been told by a doctor that you had a sleep disorder, sleep apnoea, or narcolepsy?			
8. Has anyone noticed that your breathing stops or is disrupted by episodes of choking during your sleep?			
9. Do you use illicit drugs?			
9.1. Have you ever been treated for alcohol or substance abuse			
10. Do you use any drugs or medications not prescribed for you by a doctor?			
11. If you are going on an unaccompanied posting, do any dependants have a significant ongoing illness/condition? If yes, please specify			
12. Any other health problem, accidents or fractures			
13. Do you drink alcohol? If yes, what is your average weekly intake?			
13.1. When was the last time you had more than 4 drinks (female) or 5 drinks (male) in 1 day in the past 3 months			

**STATEMENT:** I have read the above questions and the above answers are correct and no information concerning my present or past state of health has been withheld. I understand and agree that this form will be held as a confidential record by Shell Health and may be copied (by paper or secure electronic transmission) to the Senior Medical Office of my future Shell employing company. The Shell employing company in question may be based in a country outside the European Economic Area (EEA) and the country may therefore have a different level of protection for an individual's rights than those countries within the EEA

**Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

Full Name (Please underline Surname)	DOB:
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**FOR COMPLETION BY EXAMINING DOCTOR****Further details of medical history since last examination**

N = Normal    A = Abnormal, please describe			PHYSICAL EXAMINATION (optional)	
N	A			
		1. HEENT (Head/eyes/ear, nose & throat)		
		2. Lungs & Chest		
		3. Cardiovascular System		
		4. Abdo. Viscera/Hernial Orifices		
		5. Genito-urinary/Anus and Rectum		
		6. Extremities		
		7. Musculo-skeletal		
		8. Skin & Varicose Veins		
		9. Central Nervous System		
		10. Other (on indication)		

HEIGHT cm	WEIGHT kg	BMI	B.P.	PULSE	HEARING L  R	VISION  Uncorrected  Corrected	DISTANT R   L	NEAR R   L	COLOUR VISION	BLOOD GROUP
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N	A	AS INDICATED <small>(No. 1 &amp; 2- only for employee &amp; dependents aged &gt;40yrs)</small>	LABORATORY AND SPECIAL INVESTIGATIONS	N	A	COUNTRY VISA REQUIREMENTS <small>For prospective employee only (-for application of work permit-) Following MOH Brunei requirement</small>
		1. Cardiovascular Screen profile (age>40): ..... %				1. Chest X-ray
		2. -Total Cholesterol				2. HIV Antibody
		- Chol /HDL ratio				3. Malaria Parasite
		- HDL				4. HBsAg
		- LDL				5. VDRL/TPHA
		- Triglyceride				6. HCV
		3. Fasting Glucose & HbA1C (for diabetics)				7. Drug Screen: Methamphetamines, Opiates, Cannabis, Benzodiazepines
		4. ECG (only if clinically indicated)				8. Pregnancy test (for female)
		5. Urine analysis				

**PLEASE ATTACH COPIES OF IMPORTANT SPECIALIST REPORTS OF CURRENT INTEREST**

**ASSESSMENT AND RECOMMENDATIONS**

<input type="checkbox"/>	Medically FIT
<input type="checkbox"/>	Fit Restricted
<input type="checkbox"/>	Temporarily Unfit (see correspondence)
<input type="checkbox"/>	Fit Offshore/Remote Locations

Doctor's Name:	_____
Address:	_____
Date:	_____
Signature:	_____