

**British Antarctic Survey  
Polar Service Medical Examination Record.**

PERSONAL DETAILS

Surname \_\_\_\_\_ Date of Birth (dd/mm/yyyy) \_\_\_\_\_

Forenames \_\_\_\_\_ Post Title \_\_\_\_\_

***To the Examining Doctor.***

***Guidance notes are available. If you are unfamiliar with BASMU requirements please read these before completing the form. The Polar regions are a unique environment which poses very different medical challenges from anywhere else. Our criteria are therefore in some respects different from more usual screening examinations. Please complete ALL sections below.***

Date of form completion (dd/mm/yyyy) \_\_\_\_\_

**1.General**

Please discuss the BASMU 3 Questionnaire with the candidate, and summarise any significant Past Medical History. Please note specifically any allergic reactions, any adverse effects of medication, any general anaesthesia/ surgery.

Details:

Is the person registered with your practice? Yes / No

If so is his / her general health good? Yes / No

Is there any significant Family History? Yes / No

Details:

Smoking Habits

Alcohol (Units / Week)

## 2. Vital statistics

Height \_\_\_ cm                      Weight \_\_\_ kg                      **BMI** \_\_\_

Waist circumference \_\_\_cm                      Hip circumference \_\_\_cm

**If BMI is greater than 35 then the person is likely to be UNFIT for Antarctic Service. If their build suggests that this is due to muscle bulk rather than obesity please note this here, and continue with the examination. If the raised BMI appears to be due to obesity alone, there is no need to continue further.**

## 3. Vital signs

Resting Pulse Rate \_\_\_ b.p.m.

Blood Pressure \_\_\_ / \_\_\_ mm.Hg

Pulse Rhythm \_\_\_\_\_

Respiratory Rate \_\_\_

## 4. Vision

Please note:

Visual conditions / restrictions

Normal    Abnormal

Colour Vision / Ishihara

Normal    Abnormal

Comment:

## 5.Examination

For Each of the following questions please enter one of the following codes:			
Within Normal Limits		✓	
Abnormal		X	
Not Examined		--	
Please give details of abnormal findings			
		Code	Details
1	General Appearance		
2	Head and Neck		
3	Eyes		
4	Ears		
5	Nose		
6	Mouth and Pharynx		
7	Thyroid		
8	Lymph Nodes		
9	Chest and Lungs		
10	Breasts		
	(if Indicated)		
11	Heart sounds		
12	Murmurs		
13	Abdomen		
14	Organomegaly		
15	Hernial Orifices		
16	Rectal Examination		
	(if clinically indicated)		
17	Genitalia		
	(if indicated)		
18	Spine		
19	Lower limbs		

	Peripheral pulses		
	Varicose veins		
20	Upper Limbs		
	Raynauds		
21	Skin		
	Previous Cold Injury		
	Scars		
	Tattoos		
	Identifying Marks		
22	neurological status		
26	Mental Health status		
	Mood		
	Affect		
27	Gynaecological Examination		
	(if indicated)		

**Please describe any other abnormal Findings on Examination?**

**6. Investigations**

**Urinalysis results:**

**ECG** required for patients at first BASMU medical when 50 years of age and over or if clinically indicated.  
Attach ECG to papers when forwarding.

**Chest X-Ray** required only where clinically indicated. Attach results or forward when available.

**Blood Group if known.....**  
(If not know we would encourage staff to become blood donors within their own national scheme, gaining this information and providing a valuable service to society)

**For Over wintering staff only**  
**Blood group and donor screening.**  
**If you have recent results available then please record these below. Otherwise please arrange for blood to be taken. In UK this should be sent to the BTS using the bottles supplied. Results will be sent to BASMU. Overseas please send to your local laboratory and indicate the results below.**

Blood Group	.....	
Hepatitis B	Negative	Positive
Hepatitis C	Negative	Positive
VDRL	Negative	Positive
HIV	Negative	Positive

If the examining Doctor believes further tests are necessary, please indicate and attach details.

**7. Tuberculosis Screening**

Patient has visible BCG scar **YES / NO**

Comments on tuberculosis risk ( see patients BASMU 3 questionnaire)

**8. Summary**

Please summarise any relevant findings:

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**Examining Doctors Name & Address**

**Practise Stamp.**

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**Contact Telephone Number**

**FAX Number**

**Practice e-mail address**

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**Doctor's Signature.....**

**Patient Signature.....**

**Date of examination.....**