British Antarctic Survey Medical Unit (BASMU)
DDRC Healthcare
Hyperbaric Medical Centre
Research Way
Plymouth Science Park
Plymouth, Devon. PL6 8BU
Tel: 01752 438621
Email: plh-tr.ADMIN.BASMU@nhs.net

BASMU 3
Dec23 MW

Medical in Confidence

Date received @ BASMU

British Antarctic Survey
Polar Service Medical Questionnaire.

(Applicants must read the BASMU 2 information form so they fully understand and accept the nature of the medical service provided by BAS)

Surname:	**Forenames:**
Date of birth:	**Job title:**
NHS Number:	

DEPLOYMENT DETAILS (please **SPECIFY/CIRCLE** one below)				
LOCATION				
ROTHERA	SOUTH GEORGIA	HALLEY	BIRD ISLAND	
SIGNY ISLAND	SDA	OTHER		
DEPLOYMENT TYPE				
STATION BASED	FIELD BASED	SCIENTIFIC CRUISE	SHIP'S CREW	OTHER
DEPLOYMENT LENGTH				
SUMMER ONLY		OVERWINTER		
Appropriate time deployed, please specify in weeks or months				
Employer whilst deployed		BAS STAFF	OTHER PLEASE SPECIFY	

BASMU USE ONLY. Final Fitness Category Decision.

M0 Unfit for service in Antarctica / Arctic.

Reason……

M1 In all respects fit for Antarctic / Arctic overwintering service.
M2 Fit for service re Antarctic / Arctic deep field deployment.
M3 Fit for service re Antarctic / Arctic summer only, ship / coastal stations.
M4 Fit for service subject to regular medical review (usually annual although shorter intervals may be specified by MO)

Details…….

Signature: **Date:**

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Your Address: _____

_____Post/Zip Code _____

Home Telephone: _____Work Telephone: _____

Mobile Tel_____E-mail_____

All questions MUST be answered. Circle or highlight YES or NO, add detail if required. The more you tell us about ongoing problems the less we will have to come back to you, or your GP for more information. Remember, BASMU tries to work with people who have medical problems to enable deployment if at all possible. We consider each case on its merits and only occasionally have to stop someone deploying on health grounds.

Section1:1 Medication. Please list *all* medications that you take prescribed and over the counter, including dosages and reasons. Continue on a separate sheet if necessary.

Section1:2 Allergic and Immune Disorders	**Details or Doctor's Comments**
We will share food allergy information with the Doctors on base / ship and the BAS Supply Chain Manager	
1.2 Allergy to medicine	YES / NO
1.3 Allergy or intolerance to food (specify)	YES / NO
1.4 Allergy to bites or stings	YES / NO
1.5 Anaphylaxis	YES / NO
1.6 Eczema	YES / NO
1.7 Hay fever	YES / NO
1.8 Splenectomy	YES / NO
1.9 HIV / AIDS	YES / NO
1.9 Immune suppressing medication	YES / NO
1.10 Organ transplant	YES / NO

If you have answered **YES to any of the above,** please add detail below.

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1.2 – 1.5 Continued – Allergy/Anaphylaxis

Do you carry an Epipen? Y / N Have you ever had to use it? Y / N

1.2 When having a reaction to food, medicine, bites and stings, have you had any of the following?

Tongue and/or throat swelling?	Y / N
Difficulty talking – hoarse voice?	Y / N
Shortness of breath/wheeze/persistent cough?	Y / N
Persistent dizziness or collapse?	Y / N
Loss of consciousness?	Y / N
Any gastrointestinal symptoms (e.g. vomiting)?	Y / N
Sense of impending doom or visual changes?	Y / N
Been hospitalised and required treatment?	Y / N
Have you ever had any allergy testing?	Y / N

Have you now, or have you previously had any of the following conditions?

Section 2. Cardiovascular		**Details or Doctor's Comments**
2.1	High blood pressure	YES / NO
2.2	Heart attack / infarction	YES / NO
2.3	Chest pain, angina or coronary disease	YES / NO
2.4	Palpitations or irregular heartbeat	YES / NO
2.5	Rheumatic fever or valve disease	YES / NO
2.6	Heart surgery, angiography or operation	YES / NO
2.7	Investigations for heart problems	YES / NO
2.8	Anaemia or blood disorder	YES / NO
2.9	Blood clots in legs (thrombosis) or lungs (embolus)	YES / NO
2.10	Varicose veins	YES / NO
2.11	Ankle swelling (without injury)	YES / NO

2.12 If you have answered **YES to any of the above,** please add detail below.

What was the diagnosis given?
When was the event?
Please describe what happened?
What tests did you have?
What were the results?
Are you still on medication for this?
If so, what?
Have you made a full recovery?

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Section 3. Respiratory		**Details or Doctor's Comments**
3.1	Asthma	YES / NO
3.2	Persistent cough	YES / NO
3.3	Shortness of breath	YES / NO
3.4	Collapsed lung (pneumothorax)	YES / NO
3.5	Bronchitis or emphysema	YES / NO
3.6	Pneumonia or pleurisy	YES / NO
3.7	Tuberculosis	YES / NO
3.8	Other lung disease	YES / NO

3.9 If you have answered **YES to any of the above,** please add detail below.

Asthma severity varies enormously from person to person, and it is important that we have a clear understanding of how asthma affects you.

At what age was asthma diagnosed?
How often do you have attacks?
Do you use inhalers every day?
If not, how often do you need inhalers?
Have you ever required injectable or oral steroid (prednisolone etc) tablets?
Have you ever been in hospital with asthma?
Is your asthma worse in summer or winter?
Is your asthma associated with allergy, cold, or exercise? Which?
When was your last attack?

Section 4. Abdominal or Digestive		**Details or Doctor's Comments**
4.1	Severe, recurrent or persistent indigestion	YES / NO
4.2	Hiatus hernia or reflux	YES / NO
4.3	Stomach or duodenal ulcer	YES / NO
4.4	Gall bladder disease / gallstones	YES / NO
4.5	Liver disease or hepatitis	YES / NO
4.6	Jaundice	YES / NO
4.7	Appendicitis or appendectomy	YES / NO
4.8	Bowel disease or surgery	YES / NO
4.9	Recurrent or persistent diarrhoea	YES / NO
4.10	Recurrent or persistent abdominal pain	YES / NO
4.11	Haemorrhoids (piles)	YES / NO
4.12	Anal abscess, fissure or fistula	YES / NO
4.13	Bleeding from bowels or back passage	YES / NO
4.14	Vomiting blood	YES / NO
4.15	Unexplained weight loss recently	YES / NO

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4.16 If you have answered **YES to any of the above,** please add detail below

For gastrointestinal bleeding only:

When was this?
Did you have severe bleeding from this?
(Vomiting blood or tarry stools (melaena)
Have you had any recurrence?
Did the ulcer perforate (burst)?
Did you have endoscopy (camera into stomach)? Did you have surgery?
Did you need a blood transfusion at any stage?
Were you treated for eradication of bacteria which cause ulcers?
Did you make a full recovery?

Section 5. Genito-urinary		**Details or Doctor's Comments**
5.1	Difficulty passing urine	YES / NO
5.2	Bladder infection (cystitis)	YES / NO
5.3	Kidney infection	YES / NO
5.4	Kidney stone (renal colic)	YES / NO
5.5	Other kidney disease	YES / NO
5.6	Sexually transmitted (venereal) disease	YES / NO
MALES ONLY		
5.7	Torsion of testis (twisted testicle)	YES / NO
5.8	Prostatitis	YES / NO
5.9	Epididymitis (infected testicle)	YES / NO
5.10	Ulcer on penis	YES / NO
FEMALES ONLY		
5.11	Severe or recurrent thrush	YES / NO
5.12	Up to date cervical smear test	YES / NO
5.13	Previous abnormal smear	YES / NO
5.14	Severe period pains	YES / NO
5.15	Irregular or severe menstrual bleeding	YES / NO
5.16	Endometriosis	YES / NO
5.17	Fibroids	YES / NO
5.18	Pelvic inflammatory disease (infected tube)	YES / NO
5.19	Ectopic pregnancy	YES / NO
5.20	Other gynaecological condition	YES / NO

5.21 If you have answered **YES to any of the above,** please add detail below.

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For kidney problems:
What was the diagnosis?
When was this?
Do you take any medication?
How many times have you had problems?
Have you needed surgery for this?
Have you ever needed dialysis?
When was your blood was last tested for kidney function?
Have you had a kidney transplant?
If you know the results, please attach them.
Do you have any degree of poor kidney function (renal failure)?
Have you been told that you have a high risk for kidney stones?

Section 6. Musculoskeletal		**Details or Doctor's Comments**
6.1	Fractured / broken bones	YES / NO
6.2	Dislocation or subluxation	YES / NO
6.3	Joint injuries	YES / NO
6.4	Injury to neck or back	YES / NO
6.5	Lumbago, sciatica or other back trouble	YES / NO
6.6	Gout	YES / NO
6.7	Arthritis or rheumatism	YES / NO
6.8	Ankylosing spondylitis	YES / NO
6.9	Overuse or repetitive strain injury	YES / NO

6.10 If you have answered **YES to any of the above,** please add detail below.

Which bone(s) or joint(s) were affected?
When did it happen?
How was it treated?
What residual symptoms do you have?
What (if any) effect does this have on function of your limbs?
Have you had any recurrence of the same problem, or been told that you are at higher risk (e.g. shoulder dislocation)?

6.11 If you have **answered YES to neck or back** problems, please add detail below.

When was this?
Which part of your spine was affected?
What symptoms did you have?
Did you have weakness or numbness? If so, where?
Did you have any problems with bladder or bowel associated with your spinal problem?
Did you have an MRI or CT scan? Please give the results if you know them.

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Did you have surgery? If so, what was done?
Have you made a full recovery? If not, detail current problems.
Have you had more than one episode?
Have you been told that you have a higher risk of recurrent problems?

Section 7. Neurological		**Details or Doctor's Comments**
7.1	Epilepsy or fits	YES / NO
7.2	Narcolepsy, cataplexy or seizure	YES / NO
7.3	Persistent or recurrent headaches	YES / NO
7.4	Migraine	YES / NO
7.5	Fainting or unconscious attacks	YES / NO
7.6	Dizziness or "turns"	YES / NO
7.7	Other neurological condition.	YES / NO

7.8 If you have answered **YES to any of the above,** please add detail below.

For seizures:
When was this?
What was the diagnosis / type of seizure?
Do you have recurrent problems? If so, give details of frequency, type and duration.
Are you on medication for this?
When was your last episode?
Are you allowed to drive?
If currently OK, have you been told that you have a risk of recurrence?

Section 8. Mental Health	**Details or Doctor's Comments**
8.1 Depression	YES / NO
8.2 Severe or unusual mood swings	YES / NO
8.3 Alcohol or drug dependency.	YES / NO
8.4 Post-traumatic stress disorder	YES / NO
8.5 Anxiety, panic attacks or phobias	YES / NO
8.6 Personality disorder	YES / NO
8.7 Other mental illness	YES / NO
8.8 Contact with mental health services	YES / NO
8.9 Self-Harm	YES / NO

8.10 If you have answered **YES to any of the above,** please add detail below.

Living and working, particularly over winter in high latitudes, can be a very stressful experience. We need to understand a bit more about your psychological make up. Answers to these questions will of course be kept confidential to the BASMU medical team only.

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When did you have the problem?
What was the diagnosis given to you?
How long did it last?
How many episodes have you had?
Did you receive treatment from your GP?
Did you see a psychiatrist?
Did you have counselling?
Were you on medication?
If so, are you still taking it?
Have you had any symptoms in the last year or two?
Did the problems occur out of the blue, or in response to a life event?
Have you ever worked or lived in a very isolated community?
Have you lived in a small group other than your family?
Do you consider that you are completely recovered?

Section 9. Ear Nose & Throat	**Details or Doctor's Comments**
9.1 Perforated (burst) eardrum	YES / NO
9.2 Persistent discharge from ear	YES / NO
9.3 Recurrent sinusitis	YES / NO
9.4 Deafness	YES / NO
9.5 Ringing in the ears or vertigo	YES / NO
9.6 Recurrent tonsillitis or sore throat	YES / NO
9.7 Recurrent or persistent nose bleeds	YES / NO

9.8 If you have answered **YES to any of the above,** please add detail below.

Section 10. Cancers and Tumours	**Details or Doctor's Comments**
10.1 Cancer or malignant tumour	YES / NO
10.2 Leukaemia (Cancer of Blood)	YES / NO
10.3 Hodgkin's disease or lymphoma	YES / NO
10.4 Skin cancer	YES / NO
10.5 Benign tumour	YES / NO
10.6 Breast disease or 'lumps'	YES / NO
If you have answered YES to any of the questions in section 9, please add detail at 9.7	

10.7 If you have answered **YES to any of the above,** please add detail below.

Where was your tumour?
What type was it?
When did it start?
What treatment have you had?
When was the last treatment?

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Have you had any recurrence?
What frequency of follow-ups are you having?

Section11. Eyes	**Details or Doctor's Comments**
11.1 Glaucoma	YES / NO
11.2 Cataract	YES / NO
11.3 Any other eye condition	YES / NO
11.4 Any eye injury	YES / NO
11.5 Poor sight	YES / NO
11.6 Do you need glasses constantly	YES / NO
11.7 Do you use contact lenses	YES / NO

11.8 If you have answered **YES to any of the above,** please add detail below.

Section 12. Skin Disease	**Details or Doctor's Comments**
12.1 Dermatitis	YES / NO
12.2 Psoriasis	YES / NO
12.3 Non freezing cold injury	YES / NO
12.4 Frostbite or frostnip	YES / NO
12.5 Severe burns	YES / NO
12.6 Raynaud's Disease	YES / NO
12.7 Tendency to cold hands or feet	YES / NO
12.8 Other skin problem	YES / NO

12.9 If you have answered **YES to any of the above,** please add detail below.

Section13. Metabolic and Endocrine	**Details or Doctor's Comments**
13.1 Diabetes	YES / NO
13.2 Goitre or thyroid trouble	YES / NO
13.3 Addison's disease	YES / NO
13.4 Cushing's disease	YES / NO
13.5 Other endocrine problem	YES / NO
13.6 High cholesterol or lipid	YES / NO

13.7 If you have answered **YES to any of the above,** please add detail below.

For Diabetes:
Do you have Type 1 or Type 2 diabetes?
Do you need insulin injections?
What medication do you take?
How good is your sugar and other diabetic control?

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Please send your last 6 blood sugar and HbA1C results.
Do you also have high cholesterol?
Do you have any eyesight problems with your diabetes?
Do you have any problems with the sensation (feeling) in your legs as a result of your diabetes (peripheral neuropathy)?

Section14. Miscellaneous Conditions	**Details or Doctor's Comments**
14.2 Malaria	YES / NO
14.3 Other tropical disease	YES / NO

14.4 If you have answered **YES to any of the above,** please add detail below.

Section15. How many days absence from work due to sickness or injury have you had in the last two years?

Section 16. Vaccinations

FOR EVERYONE **Please give dates of the last time you had these vaccinations:**	**Dates below**
Covid Vaccination must be provided using your **NHS Covid Pass.** All personnel are required to have had at least one vaccine.	
Diphtheria / Tetanus / Polio Due to the lack of immunoglobulin we advise a booster is required if it will be more than 10 years since last vaccination while deployed. *You will be unprotected from developing tetanus if you have not received a booster within 10 years from injury.*	
Meningitis ACWY Offers better protection than Meningitis C vaccine alone and can be given even if you have already had the Meningitis C vaccination.	
MMR (measles, mumps, rubella) A combined vaccine, usually given in childhood, but if in doubt can be given at any time.	
Quadrivalent Influenza (flu) Vaccine (Seasonal flu) Offers protection to the individual and the remote community in which they will be living. Available from October each year, may be restricted in availability from your GP, but is readily available from most high street pharmacy stores.	

FOR CERTAIN PEOPLE *as advised* **Please give dates of the last time you had these vaccinations:**	**Date:**
Hepatitis A For workers exposed to regular contact with raw human sewage.	
Tick Borne Encephalitis vaccine is a vaccination recommended for people who travel to Norway and Svalbard	

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FOR SHIP's CREW only. In addition to the above the **MCA** recommend the following:-	**Date:**
Yellow Fever (One dose provides lifetime cover)	
Hepatitis A and Hepatitis B (Seafarers who maintain sewage systems)	
Hepatitis A and Typhoid (for food handlers)	

BCG (Tuberculosis) If screening information highlights this requirement, discuss with your doctor or BASMU

Section17. Tuberculosis Risk Screening (TB):

17.1 Have you or anyone in your family ever been treated for TB? **If yes, please specify**	**YES / NO**
17.2 In the last 3 years have you lived in the same household as anyone with TB? **If yes, please specify**	**YES / NO**
17.3 In the past year have you had any of the following? **If yes, please specify**	
17.4 Cough, especially with blood-stained sputum	**YES / NO**
17.5 Unexplained weight loss, lethargy or tiredness?	**YES / NO**
17.6 Unexplained sweats or fever?	**YES / NO**

Section18. Have you ever been rejected for employment with the Armed Forces or any other organisation, or have you been discharged on medical grounds	**YES / NO**

Section 19. Have you undergone a special medical examination for your previous employment? If **YES,** please indicate:
Date:
Type:
Pass / Fail

Section 20. Have you been the recipient of a blood transfusion since 1st January 1980?	**YES / NO**

Section 21. Your doctor's details
Name:

British Antarctic Survey
NATURAL ENVIRONMENT RESEARCH COUNCIL

NHS University Hospitals Plymouth NHS Trust

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Surgery Address:
Email:
Telephone:

Section 22. Dental status
All of those deploying are required to maintain good dental hygiene and within 6 months prior to deployment should have visited their dentist for a check – up & treatment if required.
Summer only staff must provide a BASMU 7 dental form signed by their dentist
Overwintering staff must provide a BASMU 8 dental form signed by their dentist with x-rays
BASMU need to be aware of your dental status and if necessary contact your dentist, please complete:
Dentist name:
Dentist phone number:
Date you last visited your dentist
The above information is vital as the Station / Ship's Doctor (who undertakes a 3 day emergency dental techniques course) is the only practitioner available to provide treatment. If there are dental issues you wish to highlight, indicate below:-

Declaration:

- I declare that the information given relating to my medical examination is true to the best of my belief.
- I understand that any wilfully incorrect or misleading statement or omission may render me liable to disqualification from BAS employment, or exclusion from Antarctic Service.
- I understand that giving incorrect information may lead to adverse events affecting my health and the wellbeing and safety of other personnel in the Antarctic / Arctic
- I agree to keep BASMU informed of my medical status prior to deployment.
- I understand that the decision on my fitness will be communicated to the BAS Human Resources Department.

Signed …… Dated……..……

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BRITISH ANTARCTIC SURVEY
MEDICAL UNIT
Consent Declaration

You are advised to read this before you sign the declaration on Page 14, and also read the booklet BASMU2, Medical aspects of living and working in the Antarctic.

Before acceptance for employment or at a later stage during employment with BAS it may be necessary for the BASMU Medical Officer to request a report from your General Practitioner (GP) or another doctor who has been involved in your medical care.

Your written, informed, consent is necessary before the SMO can request any such report. This consent is overleaf. However, under the Access to Medical Records Act 1988, you have certain rights of access to any such report which are summarised in the following notes.

1. You do not have to give your consent, but if you do, you can decide whether you wish to see the report before it is sent to the BAS SMO. This request for access can be made either:-
   - at the time that you give your consent by signing overleaf.
   - at a later stage directly to the doctor from whom the report may be requested, before this report is returned to BAS SMO.

   If you do not give your consent, the inability to obtain up-to-date medical information may affect decisions made about your employment with BAS.

2. In the event of a request for a report being necessary and, if you decide that you wish to see any report, then BAS SMO will:
   - inform you that a request is being made to the doctor
   - inform the doctor that you wish to see the report before it is sent.

   You will then have 21 days in which to contact the doctor about arrangements for you to see the report.

3. Whether or not you say that you wish to see the report before it is sent to the BAS SMO, the reporting doctor must allow you to see a copy, upon request, for up to six months after it is supplied. If you request a copy of any report, the doctor may charge a reasonable fee for this service.

4. Once you have seen the report, the doctor cannot release it to the BAS SMO without your consent. You are entitled to write to the doctor requesting amendment of any part of the report which you consider to be incorrect or misleading or to have attached to the report a statement of your views on any part where you and the doctor are not in agreement but which the doctor is not prepared to alter.

5. The doctor is not obliged to let you see any part of a report if, in his/her opinion, it would be likely to:-

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- cause serious harm to your physical or mental health, or that of others.
- indicate the doctor's intentions towards you.
- would reveal information on, or the identity of another person who has supplied information about you unless that person has consented, or the information relates to, or has been supplied by a health professional involved in caring for you.

In such cases the doctor must notify you and you will be limited to seeing any remaining part of the report. If the whole report is involved, this must not be returned to BAS without your consent.

6. In the interests of your optimal care and for operational reasons, in the event that a report is requested whilst you are serving overseas, the declaration that you are asked to sign contains your agreement to any such report being supplied without your having sight of it. This does not affect your statutory rights and you may apply within six months to the reporting doctor for a copy.

Declaration & Consent

I hereby authorise the British Antarctic Medical Unit Senior Medical Officer to request at his/her discretion a medical report from my General Practitioner (GP) listed above or other practitioner and access to information from my medical records held by my GP or other medical attendant.

I have been informed of my statutory rights under Access to Medical Reports Act of 1988.

I am aware of the limitations of medical support and medical facilities in the Antarctic as indicated in the booklet BASMU 2, Medical Aspects of Deployments in Polar Regions.

(Delete as appropriate)

I wish / I do not wish to see the report before it is supplied to the BAS Medical Unit. In the event that a report is requested whilst I am serving overseas, I agree to this report being supplied without my having sight of it.

`

Print Full Name ……

Date of birth ……

Signature .....

Date ……

Address .....

.....