

MEDICAL QUESTIONNAIRE for completion by all applicants and employees

The information you provide on this form will be kept entirely confidential. It is required to enable us to ensure your safety and the safety of others. If you are not clear on any points these can be discussed at your initial interview.

It is essential that the form is completed honestly and fully. Applicants must hand it in not later than your initial interview as a decision on your application cannot be made until we have seen the completed form.

Surname (Print) First Name(s) (Print)
Date of Birth 19..... Date of Initial Interview 200.....

MEDICAL HISTORY

Please indicate if any of the following apply or have applied to you in the past by marking (i) Yes or No in the box, as appropriate, to all 22 sections. Failure to (i) any section will be regarded as a "yes" response. Minor problems, eg: flu, minor injuries - should be ignored.

	Yes	No
1. Circulatory problems - e.g. varicose veins, phlebitis, thrombosis, numbness?	<input type="checkbox"/>	<input type="checkbox"/>
2. Heart problems; eg: angina, heart murmur, heart attack?	<input type="checkbox"/>	<input type="checkbox"/>
3. High blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
4. Chest problems; eg: asthma, breathlessness?	<input type="checkbox"/>	<input type="checkbox"/>
5. Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
6. Epilepsy or fainting attacks?	<input type="checkbox"/>	<input type="checkbox"/>
7. Psychiatric or psychological problems?	<input type="checkbox"/>	<input type="checkbox"/>
8. Skin disorders?	<input type="checkbox"/>	<input type="checkbox"/>
9. Operation or fracture within the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
10. Alcoholism or drug abuse?	<input type="checkbox"/>	<input type="checkbox"/>
11. Back trouble, arthritis, rheumatism?	<input type="checkbox"/>	<input type="checkbox"/>
12. Trouble with bones, joints, tendons, including wrist tendons?	<input type="checkbox"/>	<input type="checkbox"/>
13. Repetitive strain injury?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
14. Problems with eyesight or hearing?	<input type="checkbox"/>	<input type="checkbox"/>
15. Migraine or persistent headaches?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
16. Stress or stress related problems?	<input type="checkbox"/>	<input type="checkbox"/>

17. Any other significant health problems?

18. Have you worked in an industry with high noise levels?

20. Have you ever been found medically unfit for work?

18. Have you ever claimed for industrial or other injury, disease or illness?

19. Are you now on any medication?

20. Have you been on medication in the past 5 years?

If you have ticked 'Yes' to any of the above please provide details here:

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I hereby declare that the above information is correct to the best of my knowledge.

Signature

Date 20.....