MEDICAL QUESTIONNAIRE (STRICTLY PRIVATE AND CONFIDENTIAL)

Name: ________________________________ Date of Birth: ________________________

Please complete the questionnaire below. The information is required with your interests in mind and will be retained in strict confidence. If further information is required from your medical practitioner, your written consent will be obtained beforehand. You may be referred to a doctor appointed by the company so that a medical examination can be carried out.

Have you ever	Yes	No	Please give details
1. Had an operation?	☐	☐	
2. Been seriously injured?	☐	☐	
3. Received in-patient treatment for a physical or mental condition?	☐	☐	
4. Been refused or dismissed from employment for health reasons?	☐	☐	
5. Received a disability pension?	☐	☐	
6. Had a disability?	☐	☐	
7. Been made ill by your work?	☐	☐	
8. Been refused a driver's licence because of ill health?	☐	☐	

Do you suffer from or have you ever had:

Diabetes	Yes ☐ No ☐	Skin rashes/ eczema	Yes ☐ No ☐	Swelling of legs/ankles	Yes ☐ No ☐
High blood pressure	Yes ☐ No ☐	Anaemia	Yes ☐ No ☐	Menstruation or prostate problems	Yes ☐ No ☐
Asthma	Yes ☐ No ☐	Headaches (frequent)	Yes ☐ No ☐	Varicose veins	Yes ☐ No ☐
Cough (frequent)	Yes ☐ No ☐	Heart trouble	Yes ☐ No ☐	Rupture	Yes ☐ No ☐
Rheumatic fever	Yes ☐ No ☐	Chest trouble	Yes ☐ No ☐	Back trouble	Yes ☐ No ☐
Arthritis	Yes ☐ No ☐	Fainting or dizziness	Yes ☐ No ☐	Ear trouble	Yes ☐ No ☐
Epilepsy/fits	Yes ☐ No ☐	Hay fever	Yes ☐ No ☐	Eye trouble	Yes ☐ No ☐

Do you take medicine regularly?	Have you worked in a dusty trade?	Have you ever had a head injury?	Do you suffer from any other ailments?
Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

Name & Address of Own Doctor

Declaration:

The information contained on this form is correct to the best of my knowledge and belief. I understand that if I am appointed and this information is found to be incorrect then I am liable to dismissal.

Signature: **Date:**