



CONFIDENTIAL MEDICAL QUESTIONNAIRE

ALL INFORMATION GIVEN BELOW WILL BE TREATED IN THE STRICTEST CONFIDENCE

| |
|-----------|
| FULL NAME |
|-----------|

| |
|---------------------------|
| NATIONAL INSURANCE NUMBER |
|---------------------------|

| | | |
|---|-----|----|
| Have you had any serious illness or hospital treatment during the past five years | YES | NO |
|---|-----|----|

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| If yes please give details: |
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| Do you have any Allergies? If so what are they: |
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|-----------------------|---------------|------------------|
| Is your eyesight good | With glasses: | Without glasses: |
|-----------------------|---------------|------------------|

| | | |
|-----------------------|----------------------|-------------------|
| Is your hearing good: | Without hearing aid: | With Hearing Aid: |
|-----------------------|----------------------|-------------------|

| Have you ever had any of the following illnesses? | YES | NO |
|---|-----|----|
| Rheumatic fever or rheumatism? | | |
| Fits? | | |
| Gastric Trouble? | | |
| Heart Disease? | | |
| Fainting Attacks? | | |
| Hernia (rupture)? | | |
| Headaches? | | |
| Nervous trouble? | | |
| Industrial Dermatitis? | | |
| Urinary Complaints? | | |
| Varicose Veins | | |
| Asthma problems? | | |

If you have answered YES to any of the above please use the space bellow to give more details:

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| Have you taken any sedatives/.sleeping pills/tranquillisers? (delete as necessary) |
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| Have you ever met with a serious accident or undergone a major operation: If so please give details: |
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| Do you suffer from any back problems that may effect your ability to work: If so please give details: |
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|-----------------------------|
| Are you in good Health now? |
|-----------------------------|

| Are you receiving medical treatment at present? | YES/NO | If yes please give details |
|---|--------|----------------------------|
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| | | |

| Please provide information about any condition that may require special working arrangements to be made: |
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| What is the name, address and telephone number of your medical practitioner: |
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**TO WITHHOLD INFORMATION OR MAKE FALSE STATEMENTS ON THIS FORM
RENDERS THE EMPLOYEE LIABLE TO DISMISSAL**

I declare the above to be a true statement:

| | |
|----------------|--------------|
| Signed: | Date: |
|----------------|--------------|