Medical Questionnaire

Instructions: Print clearly in black or blue ink. Answer all questions. Sign and date the form.

**PERSONAL INFORMATION**

First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do You Smoke? Yes No

|  |  |  |
| --- | --- | --- |
| No of cigarettes/cigars per day: |  |   |
| Did you ever smoke? |  |   |
| When did you stop? |  |   |

Do You Drink Alcohol? Yes No

|  |  |
| --- | --- |
| No of units per week: |  |

(Note: 1-unit alcohol = 1 standard glass of wine, 1/2-pint beer, 1 standard shot spirits)

Do You Exercise? Yes No

|  |  |
| --- | --- |
| Type: |   |
| Frequency: |   |

|  |  |  |  |
| --- | --- | --- | --- |
| **Do you suffer from or have you ever had?** | **Yes** | **No** | **Details (incl dates)** |
| Fainting/Dizziness/Fits/Blackouts/Epilepsy |   |   |   |
| A fear of height or open spaces? |   |   |   |
| A fear of confined spaces (claustrophobia) |   |   |   |
| Recurrent headaches or Migraine |   |   |   |
| Mental illness or nervous trouble |   |   |   |
| Stress related illness / Anxiety or depression |   |   |   |
| Eye disorder or disturbance of vision |   |   |   |
| Ear trouble, infections or deafness |   |   |   |
| Did you ever work in a noisy environment |   |   |   |
| Hay Fever or Sinusitis |   |   |   |
| Asthma |   |   |   |
| Bronchitis, Pneumonia or Pleurisy |   |   |   |
| Shortness of breath or wheezing |   |   |   |
| Tuberculosis |   |   |   |
| High Blood Pressure |   |   |   |
| Chest pain, tightness or palpitations |   |   |   |
| Any heart disease or disorder? |   |   |   |
| Varicose vein trouble or ankle swelling |   |   |   |
| Anaemia |   |   |   |
| Dermatitis, eczema or skin allergy |   |   |   |
| Stomach trouble, indigestion/heartburn or ulcers |   |   |   |
| Jaundice or hepatitis |   |   |   |
| Chronic diarrhoea or constipation |   |   |   |
| Urine or kidney trouble |   |   |   |
| Diabetes, thyroid disease or other glandular disorder |   |   |   |
| Back or neck trouble |   |   |   |
| Rheumatism, tendonitis or other joint trouble |   |   |   |
| Uterine, ovarian or menstrual trouble |   |   |   |
| Cancer or benign tumours or cysts |   |   |   |
| Any other significant medical condition |   |   |   |

|  |  |  |  |
| --- | --- | --- | --- |
| **Additional Queries** | **Yes** | **No** | **Details (incl dates)** |
| Are you allergic to any drugs or chemicals |   |   |   |
| Have you been off work in the last 2 years because of illness or injury? |   |   |   |
| Have you ever had to give up a job for health reasons or injury? |   |   |   |
| Have you ever had pain or discomfort when bending or lifting? |   |   |   |
| Do you ever get aches in your neck or shoulders? |   |   |   |
| Have you ever had a compensation claim against an employer because of an accident or ill health? |   |   |   |

I hereby certify that I voluntarily completed this questionnaire. The answers to these questions are accurate to the best of my knowledge.

I also authorise the Company Occupational Physician to liaise with my Family Doctor concerning my health at any time in the future.

I acknowledge that failure to disclose information, or submission by me of information that is subsequently found to be false may render my employment Null and Void

I agree to undergo such medical surveillance as thought appropriate by the Company Occupational Physician.

**Signed**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employee No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Employee

Department \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 On behalf of the Company