



PRE-EMPLOYMENT MEDICAL QUESTIONNAIRE

Name..... Date of Birth/...../.....

Address

Have you suffered from any of the following: Please tick. (if YES, please PRINT full details)

		YES	NO	DETAILS
1	Tuberculosis			
2	Typhoid, Paratyphoid or Enteric Fever			
3	Infectious Enteritis (Salmonella)			
4	Dysentery			
5	Diarrhoea or vomiting lasting more than 24 hours in the last 3 months			
6	Infective Hepatitis			
7	Scarlet Fever			
8	Chronic skin disease, including infected cuts in the last 3 months			
9	Discharge from eyes, nose, ears and throat			
10	Disease of gums, throat or mouth			

SECTION 2 – GENERAL HEALTH QUESTIONS

Have you had or do you suffer from any of the following: (PLEASE PRINT DETAILS)

		YES	NO	DETAILS
1	Epilepsy, Fits, Blackouts? If yes, please specify which condition... When did you last have an attack? Have you had any medication prescribed for this condition? If so, what?			
2	Back injuries, Disc trouble? If yes, please specify the nature of the injury and when it was diagnosed. Were you hospitalised? Did you have an operation?			
3	Knee or ankle injuries? If yes, please specify the nature of the injury and when it was diagnosed Did you have an operation?			
4	Tenosynovitis or other repetitive strain injury? If yes, was this a single occurrence? Please specify condition... Did you have an operation?			
5	Any other injuries? When was this?			
6	Heart Disease or Blood Pressure? If yes, please specify which condition... Are you currently having treatment? When was this condition diagnosed?			
7	Pneumonia, Bronchitis, asthma or other chest injuries? If yes, please specify which condition... Are you currently having treatment? When was this condition diagnosed?			
8	Diabetes? If yes, when was this condition diagnosed?			
9	Defective hearing?			

SECTION 2 – GENERAL HEALTH QUESTIONS Cont'd

		YES	NO	DETAILS
10	Migraine? Severe headaches? How frequently?			
11	Vertigo, dizziness or any other condition which may affect you working at heights? If yes, please specify which condition... What treatment are you receiving?			
12	Do you have any allergies, e.g. drugs, plasters, chemicals? If yes, what are you allergic to?			
13	Have you had time off work for: A. Long term sickness? B. Accident at work? C. If yes, please specify the reason and length of absence...			
14	When did you last have a tetanus injection?			
15	Have you ever had a chest x-ray? If so, when and what was the result?			
16	Is your vision normal in both eyes?			
17	Do you wear glasses or contact lenses? If yes, when do you wear them? When did you last have an eye test?			
18	Are you colour blind?			
19	Are you taking any drugs at present? If yes, what are they? For what have they been prescribed?			
20	Has your doctor told you NOT to take a particular painkiller?			
21	Are you under the care of your doctor and receiving treatment now?			
22	Have you any Bladder or Bowel disorders? If so, specify which... Are you currently having treatment? When was this condition diagnosed?			

Please enter your Doctors name and address (to whom reference may be made if necessary)

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I certify that the above details have been filled in to the best of my knowledge as accurately as possible.

Signed:

ANY FALSE DECLARATION MAY RESULT IN DISCIPLINARY PROCEDURE.

Signed by (Temp): Date:

Signed by (Agency): Position: Date:

OFFICE USE ONLY

Questionnaire inspected and accepted by **APR Agency**

Signed: Name: Date: