



## 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?			