

PRE-EMPLOYMENT MEDICAL QUESTIONNAIRE

1 Personal Details

Post applied for:		Department:	
Surname:		Forename:	
Date of Birth:		Telephone:	
Address:			
Name & Address of GP:			

2 Occupational History:

Has your employment ever been terminated on the grounds of ill health? yes no

Approximately how many days/weeks sickness absence did you have?

In the last twelve months: In the twelve months prior to that:

3 Medical History:

What is your height?	What is your weight?
How many units of alcohol do you consume weekly? .	
Do you smoke? .	
Are you currently taking prescribed medication? .	
Are you currently under the care of a doctor or other medical professional? .	
When did you last consult your GP and why? .	

3.1 Are you currently suffering from or have suffered from any of the illnesses listed below:

Heart trouble <input type="checkbox"/> yes <input type="checkbox"/> no	Lung disease <input type="checkbox"/> yes <input type="checkbox"/> no	Stomach/bowel trouble <input type="checkbox"/> yes <input type="checkbox"/> no	Jaundice/hepatitis <input type="checkbox"/> yes <input type="checkbox"/> no
Joint problems <input type="checkbox"/> yes <input type="checkbox"/> no	Diabetes <input type="checkbox"/> yes <input type="checkbox"/> no	Allergies <input type="checkbox"/> yes <input type="checkbox"/> no	Headaches/migraines <input type="checkbox"/> yes <input type="checkbox"/> no
Severe stress reaction <input type="checkbox"/> yes <input type="checkbox"/> no	Serious accident <input type="checkbox"/> yes <input type="checkbox"/> no	High blood pressure <input type="checkbox"/> yes <input type="checkbox"/> no	Asthma <input type="checkbox"/> yes <input type="checkbox"/> no
Hernia or rupture <input type="checkbox"/> yes <input type="checkbox"/> no	Kidney/bladder disorder <input type="checkbox"/> yes <input type="checkbox"/> no	Back/neck problems <input type="checkbox"/> yes <input type="checkbox"/> no	Fits/blackouts/epilepsy <input type="checkbox"/> yes <input type="checkbox"/> no
Depression/anxiety <input type="checkbox"/> yes <input type="checkbox"/> no	Hearing/sight problems <input type="checkbox"/> yes <input type="checkbox"/> no	Skin problems <input type="checkbox"/> yes <input type="checkbox"/> no	Surgical operations <input type="checkbox"/> yes <input type="checkbox"/> no

Continued overleaf

If you have answered "yes" to any questions in section 2 or 3 please give details and approximate dates where relevant.

I hereby declare that the information given is full and true to the best of my knowledge. I understand that if at a later date, it is discovered that I have knowingly withheld medical information, disciplinary action may be taken against me, which may include dismissal.

Signature:

Date:/...../.....

I give the Company permission to contact my GP for further particulars of my medical records should the Company so decide.

Signature:

Date:/...../.....