

### Medical Questionnaire

Name of Candidate: \_\_\_\_\_

Name & Address of Doctor: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date: \_\_\_\_\_

Have you at any time suffered from or had any symptoms of the following complaints:-  
If yes, give dates and severity of treatment

- Ulcers, gall stones or any ailment of the stomach NO/YES
- Have you been outside U.K. or Ireland during past 12 months? NO/YES
- If yes, to which countries?

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- Typhoid fever, paratyphoid fever or any other salmonella Infection likely to cause food poisoning? NO/YES
- Skin disorder e.g. eczema, contact dermatitis NO/YES
- Infection associated with your teeth or gums e.g. an abscess NO/YES
- Depression, anxiety, nervous illness or breakdown NO/YES
- Medical conditions induced by stress NO/YES
- Fainting attacks, fits, or epilepsy NO/YES
- Ailment of lungs/chest, including asthma, TB, bronchitis NO/YES
- Rheumatism, arthritis, gout, backache, disc trouble, joint/tendon disorder e.g. tenosynovitis or RSI NO/YES
- If yes, give details of any treatment you received.

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- Palpitations, shortness of breath, chest pains, blood pressure or other ailment of the heart or circulatory system NO/YES
- Any ailment affecting the kidneys or bladder NO/YES
- Diabetes, anemia or any blood or gland condition NO/YES
- Ailment affecting the eyes (indicate if colour blind) NO/YES
- Dyslexia NO/YES
- Ailment affecting the ears NO/YES
- Ailment affecting nose/throat e.g. hay fever NO/YES
- Varicose veins, rupture or hernia NO/YES
- Any condition which renders you unable to lift, carry or operate machinery NO/YES

▪ Any illness not mentioned above NO/YES

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▪ Have you ever had any special medical investigation, X-ray cardiogram? NO/YES

▪ Are you now or have you recently been on long term treatment e.g. tablets, medicine or drugs. If so, what for? NO/YES

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▪ Do you need any special aids or adaptations to assist you performing the job effectively? NO/YES

▪ Have you ever had a previous industrial accident or suffered a previous Industrial related injury. If yes please give detail NO/YES

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What is your average weekly unit consumption of alcohol? \_\_\_\_\_  
1 Unit = ½ pint of beer/single measure of spirits

Do you smoke?. NO/YES

If yes indicate the average quantity smoked in a week \_\_\_\_\_

**Please also provide the following information-:**

The number of days/periods you have been absent from work, due to illness or injury during the last 2 years

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Nature of the illness

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Do you expect to ask for leave of absence for medical reasons during the next 12 months?

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Are you allergic to penicillin, tetanus or any other medication?

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**I declare the above answers to be true and correct in every respect. I understand and accept that if any of the information given by me in this questionnaire is incorrect or untrue, that the Company has the right to terminate my employment summarily. I am prepared to undergo a full medical examination at the Company's request if this is required.**

Signed \_\_\_\_\_ Date: \_\_\_\_\_