

Pre-employment Medical Questionnaire

Please answer ALL of the following questions

Please complete the questionnaire below. The information is required with your interests in mind. As a result of the information you have given you may be referred to a doctor appointed by the company so that a medical examination can be carried out.

Name:	Date of Birth
Job title proposed employment	Location

		If Yes, please give details
1. As far as you know, do you have any current illness or health problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Are you taking, or have you during the last 3 months been prescribed medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Have you ever had or been admitted to hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Have you ever been made ill by your work?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Have you ever been refused a driver's licence because of ill health	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Have you every notified DVLA of any medical condition that may affect your driving?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Are you colour blind and do you require correction for driving?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Do you receive a disability pension?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Been refused or dismissed from employment for health reasons	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Do you need reading glasses	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you worked in a dusty trade?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had an head injury	<input type="checkbox"/> Yes <input type="checkbox"/> No
-----------------------------	---	-----------------------------------	---	----------------------------------	---

Diabetes	Yes/no	Skin rashes/eczema	Yes/no	Swelling of legs/ankles	Yes/no
High blood pressure	Yes/no	Anaemia	Yes/no	Prostate problems	Yes/no
Asthma	Yes/no	Headaches (frequent)	Yes/no	Varicose veins	Yes/no
Cough (frequent)	Yes/no	Heart trouble	Yes/no	Rupture	Yes/no
Rheumatic fever	Yes/no	Chest trouble	Yes/no	Back trouble	Yes/no
Arthritis	Yes/no	Fainting/dizziness	Yes/no	Ear trouble	Yes/no
Epilepsy/fits	Yes/no	Hay fever	Yes/no	Eye trouble	Yes/no
Shortness of breath	Yes/no	Jaundice	Yes/no	Nerve trouble	Yes/no

I declare that the above answers are, to the best of my belief, true and complete. I understand that if I am appointed and the information I have given is incorrect, I will be liable for dismissal.

Signature: _____ Date: _____