Strictly Confidential
Medical Questionnaire

Name _____ **Date of Birth** _____

Job Applied for _____ **Blood Group** (if known) _____

A. Have you ever		**Yes**	**No**	**If you have answered yes to any of the questions left Please give details:**
1	Had an operation?	☐	☐	
2	Been seriously injured?	☐	☐	
3	Been refused or dismissed from employment for health reasons?	☐	☐	
4	Been in an accident that caused you any injury	☐	☐	

B. Have you suffered from or ever had	**Yes**	**No**		**Yes**	**No**
Heart Trouble	☐	☐	Hearing problems	☐	☐
Lung Trouble	☐	☐	Back Trouble	☐	☐
Epilepsy/Fit	☐	☐	Fear of heights	☐	☐
Hand/arm trouble	☐	☐	Colour blindness	☐	☐
Leg/knee trouble	☐	☐	Eczema or Psoriasis	☐	☐
Eye Conditions	☐	☐	Dyslexia	☐	☐
Corrective lenses required	☐	☐			

If you have answered yes to any of the above please give details:

C. Do you:	**Yes**	**No**	**If you have answered yes to any of the questions left Please give details:**
Take medicine regularly?	☐	☐	
Suffer from any other ailment or condition?	☐	☐	
Suffer from Migraine	☐	☐	
Suffer from Anaphylaxis (allergy to nuts)	☐	☐	
Suffer from Asthma	☐	☐	

D. Do you consider yourself fit for work that requires

	Yes	**No**	**If not, please give details**
Lifting	☐	☐	
Carrying	☐	☐	
Standing	☐	☐	

E. How many days illness have you had in the past year?

F. To the best of my knowledge, I have answered all the above questions correctly.

Signed: _____ Date: _____