

# Confidential Medical Questionnaire

To be completed by applicant during the interview process.

Name:

Date:

Position/Job:

Do you suffer from or have suffered from any of the following?	Yes	No	Medical treatment details
Alcohol or drug dependencies	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma, Hay fever, Sinusitis, Bronchitis or Breathlessness?	<input type="checkbox"/>	<input type="checkbox"/>	
Allergy to any drugs, substances, foods, materials, climate or dust?	<input type="checkbox"/>	<input type="checkbox"/>	
Migraine or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	
High or Low Blood Pressure?	<input type="checkbox"/>	<input type="checkbox"/>	
Skin problems, rashes, reactions to substances, dry skin, allergy to bites or stings, or drugs?	<input type="checkbox"/>	<input type="checkbox"/>	
Infectious diseases, eg Hepatitis, Chickenpox, Measles?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had any vaccinations (including childhood vaccinations) eg for travel, work?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Epilepsy, fainting fits or blackouts?	<input type="checkbox"/>	<input type="checkbox"/>	
Any history of serious illness or injury as a child or as an adult?	<input type="checkbox"/>	<input type="checkbox"/>	
Any fractures, joint pain or injury, muscular strain or sprain, tendon or ligament trouble, back injury or back pain?	<input type="checkbox"/>	<input type="checkbox"/>	
Any problems with varicose veins or feet problems, bunions, swollen ankles?	<input type="checkbox"/>	<input type="checkbox"/>	
Ear Infections, injuries or hearing loss?	<input type="checkbox"/>	<input type="checkbox"/>	
MVA, sporting injuries, work related injury or illness?	<input type="checkbox"/>	<input type="checkbox"/>	
Any claim for injury or occupations illness?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever worked in dusty or noisy conditions?	<input type="checkbox"/>	<input type="checkbox"/>	
Injury involving repetitive movements or repetitive lifting, or heavy lifting?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you presently on any medications?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever undergone any operations?	<input type="checkbox"/>	<input type="checkbox"/>	

## Declaration:

I declare that the above information is accurate to the best of my knowledge. I understand this information is required to ensure the health and safety of myself in carrying out my duties.

If the information given above requires the company to have my treating doctor's approval to perform the tasks, I agree to provide the company a letter from my doctor stating this to be.

Applicant's Signature: