



## MEDICAL QUESTIONNAIRE

Applicants should read the following carefully

The questionnaire below should be completed as fully as possible. All questions must be answered. The information will be treated in strictest confidence.

**WARNING:** In completing the questionnaire, you are responsible for the accuracy of your statements. If information is withheld, suppressed, deliberately misleading or false, you may be liable, if employed to be dismissed.

	YES	NO
1.* Do you presently suffer from any illness that requires doctor, hospital or clinic visits?	<input type="checkbox"/>	<input type="checkbox"/>
2.* Are you currently taking any medications, on a special diet, or physical therapy?	<input type="checkbox"/>	<input type="checkbox"/>
3.* Have you been hospitalized or had a surgical operation within the last five years?	<input type="checkbox"/>	<input type="checkbox"/>
4.* Do you have any allergies?	<input type="checkbox"/>	<input type="checkbox"/>
5.* Have you ever been refused life insurance?	<input type="checkbox"/>	<input type="checkbox"/>
6.* Have you ever been received disability payments or been discharged due to ill health?	<input type="checkbox"/>	<input type="checkbox"/>
7.* Have you had any of the following conditions?		
• Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
• Cancer	<input type="checkbox"/>	<input type="checkbox"/>
• Heart or circulatory problems including High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
• Psychiatric problems	<input type="checkbox"/>	<input type="checkbox"/>
• Lung problems including TB	<input type="checkbox"/>	<input type="checkbox"/>
• Neurological problems including migraine or epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
• Gastrointestinal problems including ulcers, rectal bleeding	<input type="checkbox"/>	<input type="checkbox"/>
• Diabetes or Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
• Urinary problems	<input type="checkbox"/>	<input type="checkbox"/>

YES NO

- Gynaecological problems (female)  YES  NO
  - Arthritis, limb or joint problems  YES  NO
  - Skin problems  YES  NO
8. Have you had TB testing?  YES  NO
9. Have you been immunized against Hepatitis B  YES  NO
10. Is your sight in each eye good enough for all usual activities?  
• Do you wear glasses or contact lenses?  YES  NO
11. Is your hearing in each ear good enough for all normal activities?  YES  NO
12. Do you smoke, if so how many  per day?  YES  NO
13. What was the date of your last medical examination?
14. What was the date of your last Chest X-ray?
15. How many sick days leave have you had in the past three years?
16. Please indicate : Height :  Weight :

\* If you have answered YES to any of the above, please give a detailed explanation in this section. Use reverse side if necessary.

**REMARKS:**

I declare to the best of my knowledge all the foregoing is correct. I fully understand that a health interview or examination may be required.

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

I agree that, if required, a medical report may be obtained from my doctor or a specialist. I understand that the report will be treated in confidence.