KINGDOM OF SAUDI ARABIA
MINISTRY OF DEFENCE AND AVIATION
Chief of Staff Command
Armed Forces Medical Services Department
Program/Hosp. ....

M.S.D.

المملكة العربية السعودية
وزارة الدفاع والطيران والمفتشية العامة
رئاسة هيئة الأركان العامة
الإدارة العامة للخدمات الطبية للقوات المسلحة
برنامج/مستشفى ....

MEDICAL QUESTIONNAIRE استبيان طبي

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.

NAME: HEIGHT: WEIGHT: DATE OF BIRTH:

	Please complete the following:	YES	NO
1*	Do you presently suffer from any illness that requires doctor, hospital or clinic visits?		
2*	Are you currently taking any medications, on a special diet, or physical therapy?		
3*	Have you been hospitalized or had a surgical operation within the last five years?		
4*	Do you have any allergies?		
5*	Have you ever been refused Life Insurance?		
6*	Have you ever received disability payments or been discharged due to ill health?		
7*	Have you had any of the following conditions?		
	> Hepatitis		
	> Cancer		
	> Heart or circulatory problems including High Blood Pressure		
	> Lung problems including TB		
	> Psychiatric problems		
	> Neurological problems including migraine or epilepsy		
	> Gastrointestinal problems including ulcers, rectal bleeding		
	> Diabetes or Thyroid problems		
	> Urinary problems		
	> Gynecological problems (female)		
	> Arthritis, limb or joint problems		
	> Skin problems		
8	Have you had TB skin testing?		
9	Have you been immunized against Hepatitis B?		
10	Is your sight in each eye good enough for all usual activities?		
	> Do you wear glasses or contact lenses?		
11	Is your hearing in each ear good enough for all normal activities?		
12	Do you smoke? If so, how many per day?		
13	What was the date of your last medical examination?		
14	What was the date of your last X-ray?		
15	How many sick days leave have you had in the past three years?		

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

Date: Signature:

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.

Date: Signature:

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