CONFIDENTIAL MEDICAL QUESTIONNAIRE

ALL INFORMATION GIVEN BELOW WILL BE TREATED WITH THE STRICTEST CONFIDENCE

Full Name	

Have you had any serious illness or hospital treatment during the past five years?	YES	NO
If YES please give details?		

Is your eyesight good?	Yes – with glasses	Yes – without glasses	No
Is your Hearing good?	Yes – with hearing aid	Yes – without hearing aid	No
If NO please give details?			

Have you ever had any of the following?	Yes	No
Gastric Trouble?		
Heart Disease?		
Fainting Attacks?		
Hernia (rupture)?		
Headaches?		
Nervous trouble?		
Industrial Dermatitis?		
Urinary Complaints?		
Varicose Veins?		
Asthma problems?		
Allergies?		
Phobias?		
Back problems that may affect your ability to work?		
If you have answered YES to any of the above please give details?		

Are you in good health now?	Yes	No
If you have answered NO to the above question please give details?		

Are you currently receiving medical treatment?	Yes	No
If you have answered YES to the above question please give details?		

Please provide information about any condition that may require special working arrangements to be made:

Please provide information regarding your medical practitioner:	
Name	
Address	
Telephone Number	

Please provide information regarding your emergency contact/next of kin:	
Name	
Address	
Telephone Number	
Name	
Address	
Telephone Number	

TO WITHHOLD INFORMATION OR MAKE FALSE STATEMENTS ON THIS FORM MAY RESULT IN THE TERMINATION OF THE PLACEMENT

I declare the above to be a true statement:

Signed:

Date: