YOUR COMPANY NAME

Medical Questionnaire

Please complete this form and return it to the person who is to interview you on arrival. Information that you give will be kept entirely confidential and is required to ensure your health & safety and the safety of others.

Any points of uncertainty can be discussed during your initial interview.

Please indicate by the use of the tick boxes if any of the following apply or have applied in the past. Please give details where appropriate, in the box provided (please continue on a blank sheet if more space is required)

First Name _____ **Surname** _____

	Yes	No
Circulatory problems, varicose veins, phlebitis, thrombosis, Reynauds disease		
Heart problems, angina, high blood pressure, heart attack		
Chest problems such as; asthma, chronic bronchitis, emphysema, COPD		
Diabetes		
Epilepsy, fainting attacks, vertigo		
Skin disorders		
Recent operations or fractures		
Are you currently taking prescribed medication		
Back problems or arthritis, rheumatism, or other muscular problems		
Injury to bones, joints, tendons, including wrist tendons		
Are you pursuing and claims for industrial injury		
Have you ever worked in an industry where there were high noise levels		
Any eyesight problems, restricted vision or coloured blindness		
Have you any allergies		
Are you receiving any treatment for blood borne virus		
Have you any problems connected with hand arm vibration		

Details

I hereby declare that the above information is correct to the best of my knowledge.

Signature _____ Date _____