**HEALTH QUESTIONNAIRE FORM**

|  |  |  |  |
| --- | --- | --- | --- |
| **NO.** | **DETAILS** | **NO** | **YES** |
|  |  |  |  |
| 1 | Do you have any outstanding medical problems? |  |  |
| 2 | Are you receiving any treatment from your doctor at present which has lasted 4 weeks or longer |  |  |
| 3 | Have you any disability? if yes , are you registered disable. If yes please state R.D.P Number. |  |  |
| 4 | Are you restricted for medical reasons from carrying out any specific type of work ? eg. Working at heights or manual handling etc. |  |  |
| 5 | Have you ever been refused medical insurance on medical grounds? |  |  |
| **Do you have any of the following?** | | | |
| 6 | Heart Trouble or Blood pressure? |  |  |
| 7 | Fainting attacks, Blackouts or fits? |  |  |
| 8 | Any serious defect of vision? |  |  |
| 9 | Epilepsy |  |  |
| 10 | A fear of confined spaces? |  |  |
| 11 | Are you taking any medication at this time? |  |  |
| 12 | Diabetes? |  |  |
| 13 | Deafness of discharge from the ear? |  |  |
| 14 | Chest Trouble, asthma, bronchitis or TB? |  |  |
|  |  |  |  |
| 15 | Kidney or Bladder Trouble? |  |  |
|  |  |  |  |
| 16 | Rheumatism? |  |  |
| 17 | Stomach trouble such as an ulcer |  |  |
| 18 | Nervous or mental trouble? |  |  |
| 19 | Any illness that necessitated? |  |  |
| 20 | If yes, are there any remaining problems? |  |  |
| 21 | A Chest Xray in the last 3 years? |  |  |
| 22 | Sciatica, Lumbago or Back trouble? |  |  |
| **I certify that the information given is in this form is complete and true to the best of my knowledge.**  **Signed by employee:…………………………………………………...**  **Date :...................................................................................** | | | |