

MEDICAL SCREENING QUESTIONNAIRE

DATE: _____ **VISITORS, STAFF RETURN TO WORK AND EMPLOYMENT APPLICANTS**

Surname: _____ **Forenames:** _____

Address: _____ **Date of Birth:** _____

Tel. No. _____

Name and Address of your own General Practitioner:
DOCTOR _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING			HOW LONG OFF WORK	NAME OF DOCTOR OR HOSPITAL
	YES	NO		
1. Blackouts, Fits, Epilepsy, Fainting Attacks Dizziness or sleep walking'	<input type="checkbox"/>	<input type="checkbox"/>		
2. Mental or nervous disorder or stress (including nerves'	<input type="checkbox"/>	<input type="checkbox"/>		
3. Addiction to Drugs or Alcohol'	<input type="checkbox"/>	<input type="checkbox"/>		
4. Heart disease or disorder'	<input type="checkbox"/>	<input type="checkbox"/>		
5. High Blood pressure'	<input type="checkbox"/>	<input type="checkbox"/>		
6. Hernia or Rupture?	<input type="checkbox"/>	<input type="checkbox"/>		
7. Back or joint trouble'	<input type="checkbox"/>	<input type="checkbox"/>		
8. Typhoid, Paratyphoid or Enteric fevers	<input type="checkbox"/>	<input type="checkbox"/>		
9. Salmonella infection or Food Poisoning	<input type="checkbox"/>	<input type="checkbox"/>		
10. Bacillary Dysentery'	<input type="checkbox"/>	<input type="checkbox"/>		
11. Persistent diarrhoea or infection of the bowels	<input type="checkbox"/>	<input type="checkbox"/>		
12. Asthma, Bronchitis or Tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>		
13. Tropical disease, eg. Hookworm, Bilharzia etc	<input type="checkbox"/>	<input type="checkbox"/>		

HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING WITHIN THE PAST TWO YEARS?				
	YES	NO		
14. Chronic bronchitis with spit?	<input type="checkbox"/>	<input type="checkbox"/>		
15. Diarrhoea and/or vomiting for more than two days	<input type="checkbox"/>	<input type="checkbox"/>		
16. Skin rash or any skin disease'	<input type="checkbox"/>	<input type="checkbox"/>		
17. Recurrent boils/septic fingers?	<input type="checkbox"/>	<input type="checkbox"/>		
18. Discharge from ear?	<input type="checkbox"/>	<input type="checkbox"/>		
19. Discharge from eye?	<input type="checkbox"/>	<input type="checkbox"/>		
20. Discharge from nose?	<input type="checkbox"/>	<input type="checkbox"/>		
21. Peptic, Gastric or Duodenal Ulcer or recurren indigestion or stomach pain requiring time off work	<input type="checkbox"/>	<input type="checkbox"/>		
22. Kidney or bladder infection or disorder	<input type="checkbox"/>	<input type="checkbox"/>		
23. Eye disease, injury or significant defect of vision not correcte by spectacles?	<input type="checkbox"/>	<input type="checkbox"/>		
24. Ear disease or deafness'	<input type="checkbox"/>	<input type="checkbox"/>		

I declare that all the above statements are true and complete to the best of my knowledge and belief.

SIGNED _____ DATE _____