

CONFIDENTIAL MEDICAL QUESTIONNAIRE

Name	<input style="width: 95%;" type="text"/>
Job Title	<input style="width: 95%;" type="text"/>
GP's Name	<input style="width: 95%;" type="text"/>
GP's Address	<input style="width: 95%;" type="text"/>
	<input style="width: 95%;" type="text"/>
	<input style="width: 95%;" type="text"/>

Please complete this questionnaire. As a result of the information you have been given, you may be referred to a doctor appointed by the company so that a medical examination can be carried out.

Have you ever	No	Yes	Please give details
1. Had an operation?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Received a serious injury?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Had in-patient treatment for a physical or mental condition?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Been refused or dismissed from employment for health reasons?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Received a disability state benefit?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Had a disability?	<input type="checkbox"/>	<input type="checkbox"/>	
7. Been made ill by your work?	<input type="checkbox"/>	<input type="checkbox"/>	
8. Been refused a driver's licence on the grounds of ill health?	<input type="checkbox"/>	<input type="checkbox"/>	

Have you suffered from or ever had:

Stomach trouble Yes No Lung trouble Yes No Heart trouble Yes No

Skin disease Yes No Ear trouble Yes No Eye trouble Yes No

Do you:

Take prescription medicine regularly? Yes No Suffer from any other ailments? Yes No

To the best of my knowledge and belief, the information given above is correct. I understand that if I am appointed and the information I have provided is incorrect, I may be liable to dismissal.

Signature Date