

Personal Details

Forename:	Home Number:
Surname:	Work Number:
Address:	Mobile Number:
Postcode:	Email Address:
	Date of Birth:

General Practitioner

Full Name:	Address:
Telephone:	Postcode:

Work-Related Health History

How many days have you been absent from work or full time study due to Sickness during the last two years?

Have you ever left, or been denied a job for health reasons? Yes No

Have you ever had an illness caused by your work? Yes No

Have you ever experienced any health problems when using visual display units? Yes No

Do you suffer from any health problems which you consider may prevent you from undertaking night work? Yes No

Do you have any difficulties understanding writing or speech? Yes No

Health History

Please provide your approximate weight and height details:

Weight:	Kg/st	Height:	Cms/ft.ins
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Please complete every question

1. Are you in good health? Yes No

If answer is YES to any of the following, give details in Additional Information.

2. Are you on any treatment (tablets, injections)? Yes No

3. Have you suffered from or are you now being treated for any of the following:

a) ASTHMA, BRONCHITIS OR OTHER CHEST DISEASE	Yes <input type="checkbox"/>	No <input type="checkbox"/>
b) HEART DISEASE INCLUDING RHEUMATIC FEVER	Yes <input type="checkbox"/>	No <input type="checkbox"/>
c) KIDNEY, BLADDER OR PROSTATE DISEASE	Yes <input type="checkbox"/>	No <input type="checkbox"/>
d) EPILEPSY	Yes <input type="checkbox"/>	No <input type="checkbox"/>
e) FITS, BLACKOUTS OR FAINTING	Yes <input type="checkbox"/>	No <input type="checkbox"/>
f) HERNIA OR RUPTURE	Yes <input type="checkbox"/>	No <input type="checkbox"/>
g) RAISED BLOOD PRESSURE OR CHOLESTEROL	Yes <input type="checkbox"/>	No <input type="checkbox"/>
h) ECZEMA, DERMATITIS OR OTHER SKIN PROBLEMS	Yes <input type="checkbox"/>	No <input type="checkbox"/>
i) DIABETES	Yes <input type="checkbox"/>	No <input type="checkbox"/>
j) MIGRAINE OR HEADACHES	Yes <input type="checkbox"/>	No <input type="checkbox"/>
k) INDIGESTION	Yes <input type="checkbox"/>	No <input type="checkbox"/>
l) GASTRIC OR DUODENAL ULCER	Yes <input type="checkbox"/>	No <input type="checkbox"/>
m) SERIOUS BOWEL TROUBLE	Yes <input type="checkbox"/>	No <input type="checkbox"/>

4. Is there anything that leads you to think that you might have come into contact with the Aids Virus, or Hepatitis B or C? Yes No

5. Do you have any Allergies? Yes No

6. Have you had treatment for any of the following?

a) DEPRESSION Yes No

b) EMOTIONAL PROBLEMS Yes No

c) ANY KIND OF MENTAL ILLNESS OR NERVOUS BREAKDOWN Yes No

d) DRUG ADDICTION Yes No

e) ALCOHOLISM OR EXCESSIVE CONSUMPTION OF ALCOHOL Yes No

f) ANY OTHER ILLNESS Yes No

7. Have you ever had any surgical operations, serious accidents or injuries requiring medical or surgical treatment? Yes No

8. Have you ever had a slipped disc, sciatic pain or other neck/back problems? Yes No

9. Have you ever been rejected for Services with Armed Forces or Life Insurance Policy? Yes No

10. Do you have problems with your VISION Yes No HEARING Yes No

11. Do you take alcoholic drinks? Yes No

Average number of drinks per week (one drink is a single whisky, gin or brandy, a glass of wine, sherry or port or half a pint of beer or equivalent)

12. Do you currently smoke? Yes No

If so, how many per day or ounces/gr per week

If no, have you smoked in the last 10 years? Yes No

13. Please give details of how much exercise you do per week?

Additional Information

Have you had BCG vaccination before? Yes No

If yes. What size is your scar? (Answer in cm or mm)

Please give us vaccination dates for the following: Rubella / / Chickenpox / / Measles / /

I, the undersigned, confirm that the above is correct to the best of my knowledge.

Signed: Date:

Name:

Before returning this form, please re-read and check that all questions are answered correctly.