



# MEDICAL QUESTIONNAIRE

PLEASE ANSWER THE FOLLOWING QUESTIONS TICKING THE APPROPRIATE COLUMN. IF THE ANSWER IS YES TO ANY OF THE QUESTIONS PLEASE GIVE FURTHER INFORMATION IN THE DETAILS COLUMN.

## HAVE YOU EVER HAD:

	YES	NO	DATES	DETAILS
Asthma				
Bronchitis				
Pleurisy				
Heart or Circulatory trouble or raised blood pressure				
Blackouts, Epilepsy, fainting attacks or giddiness				
Back trouble causing time off work or disability				
Skin troubles, rash or sensitivity to drugs, food or substance				
Gastric disorders or stomach troubles				
Nervous or mental disorder or nerves				
Rupture				
Recurrent Headaches or Migraine				
Tuberculosis				
Any other illnesses including Jaundice, HIV, Hepatitis or other communicable diseases.				
Rheumatism or arthritis				
Typhoid, paratyphoid or dysentery				
Digestive or bowel disorder				
Any other accident, operation or illness				
Any other current or recent medical condition or treatment which might affect your attendance or performance at work				
Do you smoke?				
Have you had a Chest x-ray in the past year? If so give place and date  <b>Immunisation Record</b> Heaf/Mantoux Test BCG Rubella Immunity Polio NMR Hepatitis B Hepatitis A Tetanus				

How many units of alcohol do you drink per week \_\_\_\_\_ (One unit = 1/2 pint of beer OR 1 glass wine OR 1 single whisky)

### Details of the General Practitioner you attend:

Name:.....	
Address: .....	
Tel. No: .....	
I certify that I have answered all the questions to the best of my knowledge and that the answers are complete. I give permission for my doctor to be contacted to certify my fitness to work as a nurse or carer.	
Signed:.....	Date:.....