

PRE-EMPLOYMENT MEDICAL QUESTIONNAIRE**STRICTLY CONFIDENTIAL**

NAME:	DATE OF BIRTH:/...../.....
ADDRESS:	
POSITION APPLIED FOR:	LOCATION:
NAME & ADDRESS OF YOUR DOCTOR:	

Please answer ALL the following questions: YES No

- (1) Have you suffered any of the following: (if YES please provide full details on the reverse of this form)
- | | | |
|---|--------------------------|--------------------------|
| a) depression, anxiety, nervous illness or breakdown? | <input type="checkbox"/> | <input type="checkbox"/> |
| b) epilepsy or disease of the nervous system? | <input type="checkbox"/> | <input type="checkbox"/> |
| c) spinal problems, including back injury or strain or recurrent back pain? | <input type="checkbox"/> | <input type="checkbox"/> |
| d) any heart or circulatory problems, including problems of the blood? | <input type="checkbox"/> | <input type="checkbox"/> |
| e) any illness or medical condition not specified above? | <input type="checkbox"/> | <input type="checkbox"/> |
- (2) Have you ever: (If YES, please provide full details on the reverse of this form) been awarded compensation for injury sustained during the course of your employment with any previous employer? Yes No

(3) Are you presently taking any medication or undergoing any treatment? If YES, please provide full details:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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(4) Are you a registered disabled person? If YES, please provide full details.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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Signed:

Date: