# MEDICAL QUESTIONAIRE

This questionnaire accompanies your application form and must be completed in full to determine your eligibility for employment with the Cloud Vapours. Please answer all questions and sign when indicated to do so.

The information you provide on this form will be treated with the highest level of confidentiality. Please tick the appropriate boxes for the questions below:

Do you currently or have previously suffered from any of the following:

 Yes No

|  |  |  |
| --- | --- | --- |
| Heart disease, rheumatic fever, high blood pressure? |  |  |
| Lung disease including bronchitis, emphysema, asthma or TB? |  |  |
| Recurrent stomach or bowel complaint including ulcers and hernias? |  |  |
| Diabetes? |  |  |
| Kidney or urinary complaint or blood or urine? |  |  |
| Recurring headaches, fits, fainting or blackouts? |  |  |
| Anxiety, depression or any other nervous disorder? |  |  |
| Tingling, Numbness or whiteness of the finger? |  |  |
| Dermatitis, eczema or other skin disorder? |  |  |
| Repeated whitlows or infection around fingernails? |  |  |
| Typhoid, paratyphoid, cholera, dysentery, salmonella infection, gastroenteritis? |  |  |
| Back or neck pain, arthritis, other joint pain or stiffness? |  |  |
| Hearing difficulties or any other ear conditions? |  |  |
| Eye trouble? |  |  |
| Colour blindness? |  |  |
| Any other illness or disease? |  |  |
| Have you ever sought treatment for drug or alcohol dependency? |  |  |
| Have you had any serious accident or injury? |  |  |
| Are you allergic to anything? |  |  |
| Do you wear contact lenses or glasses? |  |  |
| Have you had any operation or hospital admission in the last 12 months? |  |  |
| Have you consulted a doctor within the last 2 years? |  |  |
| Are you taking any tablets or medicines? |  |  |
| Have you visited countries outside Europe and North America recently? |  |  |
| Have you been refused a driving license because of ill health? |  |  |
| Do you suffer from any other condition that may affect your working life? |  |  |
| Have you experienced difficulty when working with display screen equipment? |  |  |
| Do you need to wear medical alert jewellery? |  |  |
| Do you have any medical complaints at this current time? |  |  |
| Have you changed your patterns of work or left a position for medical reasons? |  |  |

If you have said yes to the above answers, can you please leave a comment detailing exactly what the medical concern(s) are in the box below:

|  |
| --- |
|  |

PRINT NAME

|  |
| --- |
|  |

SIGNED DATE

|  |
| --- |
|  |