

**PRIVATE & CONFIDENTIAL**
**Ref. no:** \_\_\_\_\_

**Name:** \_\_\_\_\_

**Date:**     /     /

**Position offered:** \_\_\_\_\_

*(subject to satisfactory health checks)*

If the answer is yes to any of the questions on this form, please give full details in the space provided of the dates, duration and outcome of the illness or condition. If we have any concerns about your fitness for work, employment will be subject to satisfactory medical reports.

| Have you ever had                                     | Insert Yes/No | Additional information to "Yes" response |
|-------------------------------------------------------|---------------|------------------------------------------|
| Tuberculosis, asthma, bronchitis or chest problems?   |               |                                          |
| Chest pain, heart condition or raised blood pressure? |               |                                          |
| Blackouts, fits or attacks of giddiness?              |               |                                          |
| Depression, mental illness or nervous breakdown?      |               |                                          |
| Rheumatism or arthritis?                              |               |                                          |
| Back trouble?                                         |               |                                          |
| Typhoid or paratyphoid?                               |               |                                          |
| Digestive or bowel disease?                           |               |                                          |
| Diabetes, thyroid or other gland trouble?             |               |                                          |
| Bladder or kidney trouble?                            |               |                                          |
| Dermatitis or skin trouble?                           |               |                                          |
| Varicose veins?                                       |               |                                          |

| Have you ever had                                                                                                                                                                                                           | Insert Yes/No | Additional information to “Yes” response |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|------------------------------------------|
| Any other accident, operation or illness?                                                                                                                                                                                   |               |                                          |
| Have you any reason to believe you may be infected with any communicable disease?                                                                                                                                           |               |                                          |
| Any other current or recent medical condition or treatment which might affect your attendance or performance at work?                                                                                                       |               |                                          |
| Do you intend to work night duties on a regular basis?                                                                                                                                                                      |               |                                          |
| Has any illness or medical condition prevented you from attending work on your normal duties or activities for more than one week during the past year? If yes, please specify.                                             |               |                                          |
| Do you have any physical or mental impairment which has a substantial and long term effect on your ability to carry out day to day activities? If yes, please specify any special adjustments required in relation to work. |               |                                          |
| Do you smoke?                                                                                                                                                                                                               |               |                                          |
| How many units of alcohol do you drink per week?<br>(one unit = 1 middy beer =<br>1 glass wine = 1 shot of spirits)                                                                                                         |               |                                          |