

MSS GROUP LTD EMPLOYEE MEDICAL QUESTIONNAIRE

Title: _____ **First Name:** _____ **Surname:** _____

TO THE APPLICANT

The purpose of this medical questionnaire is to find out if you should be examined by a doctor before commencing employment. A positive response to a question does not necessarily mean that you may not be employed by us. It does mean that you may have a condition that may effect your safety during your employment and you must seek the advice of a Doctor.

Please answer the following questions on your past and present medical history with a YES or NO. If you are not sure, answer YES. If any of these items apply to you, we may request that you consult a Doctor prior to your employment.

MEDICAL QUESTIONS

- Do you regularly take prescription or non prescription medicine? YES NO

- Do you have a disability which we would need to take in account? If so, how can we help? YES NO

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- Do you smoke? YES NO

- Do you lack full vision in either or both eyes which is not corrected by wearing spectacles or contact lenses? YES NO

- Have you ever worked with asbestos? YES NO

- Are you pregnant? YES NO

- Do you have a family history of heart attacks or strokes? YES NO

- Have you ever been absent from work with stress or anxiety? YES NO

HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE

- Asthma, wheezing with breathing or wheezing with exercise? YES NO

- Frequent or severe attacks of hay fever or allergy? YES NO

- Any skin conditions or reactions (I.e. dermatitis)? YES NO

- Any form of lung disease? YES NO

- History of chest surgery? YES NO

- Claustrophobia or agoraphobia (fear of confined or open spaces)? YES NO

- Behavioural health problems? YES NO

- Epilepsy, seizures, convulsions or take medication to prevent them? YES NO

- Recurring migraine headaches or take medication to prevent them? YES NO

- History of blackouts or fainting? YES NO

- Repetitive strain injury? YES NO

- History of diabetes? YES NO

- History of back, arm or leg problems following surgery, injury or fracture? YES NO

- Inability to perform moderate exercise (walk 1 mile in 10 minutes)? YES NO

- History of high blood pressure or take medication to prevent it? YES NO

- History of heart disease? YES NO

- History of heart attacks? YES NO

- History of angina or any heart or blood vessel surgery? YES NO

- History of ear problems, hearing loss or problems with balance? YES NO

- History of bleeding or other blood disorders? YES NO

- History of any type of hernia? YES NO

- History of ulcers? YES NO

- History of drug or alcohol abuse? YES NO

If you have answered yes to any of the questions asked on this sheet or wish to provide details of any other medical condition please do so overleaf.

The information I have provided about my medical history is accurate to the best of my knowledge and belief.

Employee's Signature: _____ **Date:** _____

Employee's Name: _____
(Print)