MEDICAL QUESTIONNAIRE

STRICTLY CONFIDENTIAL

Surname: Mr./Mrs./Miss/Ms._____ All Forenames_____

Address:_____

_____ Post Code_____

Age_____ Date of Birth _____ Marital Status_____

State if you have suffered from any of the following:

	YES/NO		YES/NO
Tuberculosis		Eating or Mental Disorder	
Blood Coughing		Epilepsy	
Coughing or hoarseness of long duration		Sciatica	
		Genito-Urinary Complaints	
Pneumonia or Pleurisy		Asthma	
Rheumatic Fever (Rheumatism)		Slipped Disc or Back Trouble	
Appendicitis			
Stomach or Bowel Complaint		High or Low Blood Pressure	
Diabetes		Heart condition/Angina	
Infection of Kidneys		Fainting or Migraine	

Have you ever had any specialist or hospital investigation, X-Ray or E.C.G.?_____

Is any investigation pending?
If so please specify_____

Have you suffered an injury?
If so state when and how_____

Are you at present on any form of treatment or medical advice?
If so please specify_____

Have you had any specialist advice in the last two years?_____

Have you lost any time through illness or injury in the past three years?
If so, for what and for how long_____

Do you feel in good health_____

Have any of your relatives suffered from any of the complaints listed above?
If so, please state which and the relationship of the person to you_____

How much do you smoke per day?_____

APPLICANTS SIGNATURE_____ DOCTORS SIGNATURE_____

Date_____ Date_____