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| **Pre-Employment MEDICAL Questionnaire** | | |
| Have you suffered from any of the following conditions?  (If “YES” is the answer to any of these questions, please give full details below, including dates and the period/s involved. If necessary, you may continue on a separate sheet which should also be signed and dated) | | |
| Head or eye injuries | YES/NO |  |
| Ear infection | YES/NO |  |
| Problems with hearing | YES/NO |  |
| Vertigo and/or problem with balance | YES/NO |  |
| Asthma, Bronchitis or other lung condition | YES/NO |  |
| Any skin rash or skin disease  e.g. dermatitis | YES/NO |  |
| Broken or fractured limbs | YES/NO |  |
| Back strains | YES/NO |  |
| Muscular strains | YES/NO |  |
| Any other accident, injury, illness or disease or any other condition which caused absence from work for a period of 3 days or more | YES/NO |  |
| Are you Registered Disabled? | YES/NO | Registration Number |