MEDICAL QUESTIONNAIRE

Name:	
Address	

It is important to be accurate with your answers to this questionnaire. When you declare NO, you are accepting a degree of responsibility for your own safety. Please answer the following questions and sign the declaration at the bottom.

	Yes	No
1. Do you have diabetes needing insulin?		
2. Do you suffer from epilepsy or fits?		
3. Have you ever suffered blackouts, recurrent dizziness or any condition which may cause sudden collapse or incapacity?		
4. Do you get discomfort or pain in the chest or shortness of breath on exercise (e.g. climbing a single flight of stairs)?		
5. High/low blood pressure		
6. Are you taking any medication that is causing you dizziness or drowsiness?		
7. Do you take regular medication? Please give details below		
8. Do you have problems with heights?		
9. Do you have a problem with repetitive lifting as required for the employment?		
10. Do you have any difficulty with your eyesight (other than the wearing of glasses or contact lenses where required)? E.g. colour blindness		
11. Have you ever had heart problems?		
12. Have you ever had a serious accident or operation		
13. Do you have any difficulty hearing normal conversation?		
14. Back/Neck problems		
15. Would being on your feet all day cause you a problem?		
16. Have you had a hernia?		
17. Have you had any illness related to alcohol during the last 12 months?		
18. Have you used any drug of abuse (not alcohol or tobacco) within the last 12 months?		
19. Details of any medication or serious operations		
20. Any problems due to arm and vibration syndrome?		
If you have answered yes to any of the questions above please give details here:		

Signed By;	
Date	