## MEDICAL QUESTIONNAIRE

Please indicate whether you have ever suffered, or had problems relating to, the following by entering **YES** or **NO** where applicable.

| | | | | | |
|---|---|---|---|---|---|
| Rheumatism/Arthritis | | Frequent Headaches | | Typhoid | |
| Back/Joint problems | | Allergies | | Diabetes | |
| Tuberculosis | | Shortness of Breath | | Epilepsy/Blackouts | |
| High Blood Pressure | | Bronchitis/Asthma | | Infected, ear, nose, throat | |
| Hepatitis B | | Heart Disease | | Deafness | |
| Chest Pain | | Ruptures | | Any other condition ? | |
| Dysentery | | Ulcers | | | |

If you have answered Yes to any of the above, please give details on a separate page of the illness/condition, the year the problem arose, its duration, and details of treatment given.

Please give the date and result of your last chest x-ray (if applicable): | |

Please answer **YES** or **NO** to the following questions concerning your present health: -

| | |
|---|---|
| Are you currently seeing your doctor about a problem? | |
| Are you a smoker? | |
| Have you suffered diarrhoea, sore throat, or skin trouble in the last month? | |

Have you had any illness associated with, or contact with :-

Methicillin Resistant Staphylococcus **YES/NO**
Any infectious disease **YES/NO**
Any serious physical or mental illness **YES/NO**
Any surgery that would influence work practice **YES/NO**
*If you have answered YES to any of the above questions, please give details on a separate page.*

Please state whether you have had any of the following inoculations: -

| **TYPE** | **YES/NO** | **If YES, please give the date of inoculation** |
|---|---|---|
| German Measles | | |
| Polio | | |
| BCG (TB) | | |
| Hepatitis B | | |
| Tetanus | | |

I have answered the above questions to the best of my knowledge and understanding, and I have omitted no relevant details. I certify that I am at present in good physical and mental health. I accept that I may be required to undertake a medical check. I also understand that if any false statements are knowingly made this may result in my dismissal from Keswick Care Ltd

Signed: …….. Date: …./…./….

Print Name: ……...