Sibanye Stillwater Limited
Reg. 2014/243852/06

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MEDICAL HISTORY QUESTIONNARE

Details

Full Name	
Identification Number	
Date (dd/mm/yyyy)	

Please answer all the questions below with complete honesty.

Section 1

#	Question	Answer	
1	**Have you ever had, or do you now have:**	**Yes**	**No**
1.1	Refused work on medical grounds?	Y	N
1.2	Epilepsy or fits of any kind?	Y	N
1.3	Head injury, concussion, or unconsciousness?	Y	N
1.4	Frequent headaches/dizziness/vertigo?	Y	N
1.5	Any mental or psychological disorder?	Y	N
1.6	Eye or vision trouble (except glasses)?	Y	N
1.7	Hearing or speech disorders?	Y	N
1.8	Have you had Heart Disease?	Y	N
1.9	Do you suffer from high blood pressure?	Y	N
1.10	Diabetes (sugar sickness)?	Y	N
1.11	Do you have Asthma?	Y	N
1.12	Have you been diagnosed with lung disease?	Y	N
1.13	Have you experienced Back and or neck pain?	Y	N
1.14	Have you ever had spinal surgery?	Y	N
1.15	Do you suffer from Arthritis?	Y	N
1.16	Do you have any Allergies?	Y	N
1.17	Do you experience a rash?	Y	N
1.18	Have you experienced heat cramps or been made unfit for underground work due to heat?	Y	N
1.19	Have you had an injury at work?	Y	N
1.20	Any previous Accidents or Injuries or operations?	Y	N
1.21	Have you been booked off sick in the last six months?	Y	N
1.22	Have you been admitted to hospital (for any reason) in the last 6 months?	Y	N
1.23	Any other medical condition?	Y	N

Section 2

#	Question	Answer	
2	**Tuberculosis (TB) Questions:**	**Yes**	**No**
2.1	Do you suffer from Coughing/weight loss/night sweat?	Y	N
2.2	Been in contact with a TB patient(s)?	Y	N
2.3	Have you ever been treated for TB?	Y	N
2.4	Tuberculosis? (If yes, please answer questions 2.4.1 to 2.4.4 and if No please proceed to section 3)	Y	N
2.4.1	Year (yyyy)		
2.4.2	Treatment received?	Y	N
2.4.3	Completed treatment?	Y	N
2.4.4	Was your treatment more than 6 months long?	Y	N

Section 3

#	Question	Answer	
3	Fatigue Management:	**Yes**	**No**
3.1	Do you suffer from a sleep problem? (Can't sleep, fall asleep at work, while driving?)	Y	N
3.2	Have you been told that you snore loudly or stop breathing or are choking in your sleep?	Y	N
3.3	Do you have difficulty sleeping at home when working shifts?	Y	N
3.4	Do you take any medication which causes drowsiness (or do you take medication / energy drinks to assist you to be alert?) If yes, please answer questions 3.4.1 to 3.4.6.	Y	N
3.4.1	Benzodiazepines?	Y	N
3.4.2	Anxiolytics?	Y	N
3.4.3	Sedatives?	Y	N
3.4.4	Anti-epileptics	Y	N
3.4.5	Anti-psychotics	Y	N
3.4.6	Energy Drinks - Red Bull, Monster, Rockstar, Reize, etc.?	Y	N

Section 4

#	Question	Answer	
4	**Vaccinations**	**Yes**	**No**
4.1	Have you been fully vaccinated for Covid? (2 x Pfizer, 1 x J&J, or other)	Y	N

Section 5

If male, please proceed to section 6.

#	Question	Answer	
5	**Female applicants: If male, please proceed to section 5.**	**Yes**	**No**
5.1	When was your last menstrual period? Please provide your cycle end date (dd/mm/yyyy)		
5.2	Are you currently Breast feeding?	Y	N

Section 6

#	Question	Answer	
6	**Do you use alcohol/drugs?**	**Yes**	**No**
6.1	Are you on pain medication or medication for weight loss?	Y	N
6.2	Have you previously been treated for alcohol or drug addiction?	Y	N
6.3	Are you a smoker? If Yes, please answer questions 6.3.1 to 6.3.3.	Y	N
6.3.1	How many cigarettes do you smoke per day?	Y	N
6.3.2	How many years have you been smoking?		
6.3.3	Do you smoke anything else besides cigarettes?	Y	N

Declaration

This form is used to obtain information from employees for the purpose of assisting employees in conducting an analysis on the workforce profile.

I hereby verify that the above questions are answered truthfully.
Signature:

_____