##### MEDICAL QUESTIONNAIRE (STRICTLY PRIVATE AND CONFIDENTIAL)

Name: fullName Job Title: jobTitle DOB: dob

Please complete the questionnaire below. The information is required with your interests in mind and will be retained in strict confidence. If further information is required from your medical practitioner, your written consent will be obtained beforehand. You may be referred to a doctor appointed by the company so that a medical examination can be carried out.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Have you ever** | | **Yes** | **No** | **Please give details** |
| 1. | Had an operation? | YES / NO | |  |
| 2. | Been seriously injured? | YES / NO | |  |
| 3. | Received in-patient treatment for a physical or mental condition? | YES / NO | |  |
| 4. | Been refused or dismissed from employment for health reasons? | YES / NO | |  |
| 5. | Received a disability pension? | YES / NO | |  |
| 6. | Had a disability? | YES / NO | |  |
| 7. | Been made ill by your work? | YES / NO | |  |
| 8. | Been refused a driver's licence because of ill health? | YES / NO | |  |

##### Do you suffer from or have you ever had:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Diabetes | YES / NO | Skin rashes/ eczema | YES / NO | Swelling of legs/ankles | YES / NO |
| High blood pressure | YES / NO | Anaemia | YES / NO | Menstruation or prostate problems | YES / NO |
| Asthma | YES / NO | Headaches (frequent) | YES / NO | Varicose veins | YES / NO |
| Cough (frequent) | YES / NO | Heart trouble | YES / NO | Rupture | YES / NO |
| Rheumatic fever | YES / NO | Chest trouble | YES / NO | Back trouble | YES / NO |
| Arthritis | YES / NO | Fainting or dizziness | YES / NO | Ear trouble | YES / NO |
| Epilepsy/fits | YES / NO | Hay fever | YES / NO | Eye trouble | YES / NO |

**Other**

|  |  |
| --- | --- |
| Do you currently use illicit drugs? | YES / NO |
| Do you use any drugs or medications not prescribed for you by your doctor? | YES / NO |
| Have you been in a vehicle crash since your last fitness to drive examination? | YES / NO |
| Do you take medicine regularly? | YES / NO |
| Have you worked in a dusty trade? | YES / NO |
| Have you ever had a head injury? | YES / NO |
| Do you suffer from any other ailments? | YES / NO |

##### Sleep

|  |  |
| --- | --- |
| Have you ever been tested for a sleep disorder or been told by a doctor that you have a sleep disorder, sleep apnoea or narcolepsy? | YES / NO |
| Has anyone told you that your breathing stops or is disrupted by episodes of choking during your sleep? | YES / NO |

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

**Would never doze off = 0, Slight Chance of Dozing =1, Moderate chance of dozing =2, High chance of dozing = 3**

|  |  |
| --- | --- |
| Sitting and reading | 0 |
| Watching TV | 0 |
| Sitting inactive in a public place (e.g. a theatre or a meeting) | 0 |
| As a passenger in a car for an hour without a break | 0 |
| Lying down to rest in the afternoon when circumstances permit | 0 |
| Sitting and talking to someone | 0 |
| Sitting quietly after a lunch without alcohol | 0 |
| In a car, while stopped for a few minutes in the traffic | 0 |

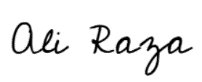
##### Alcohol

|  |  |
| --- | --- |
| Have you ever sought assistance for alcohol or substance use issues? | YES / NO |
| Have you or someone else been injured as a result of your drinking? | YES / NO |
| Has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down? | YES / NO |

Please answer that best describes your situation;

**0=Never, 1= Monthly or less, 2 = 2 to 4 times per month, 3= 2 to 3 times per week 4= 4 or more times per week**

|  |  |
| --- | --- |
| How often do you have a drink containing alcohol? | 0 |
| How many drinks containing alcohol do you have on a typical day when you are drinking? | 0 |
| How often do you have six or more drinks on one occasion? | 0 |
| How often during the last year have you found that you were not able to stop drinking once you had started? | 0 |
| How often during the last year have you failed to do what was normally expected from you because of drinking? | 0 |
| How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? | 0 |
| How often during the last year have you had a feeling of guilt or remorse after drinking? | 0 |
| How often during the last year have you been unable to remember what happened the night before because you had been drinking? | 0 |



envDate

**Date:**

**Signature:**

**Declaration:**

The information contained on this form is correct to the best of my knowledge and belief. I understand that if I am appointed and this information is found to be incorrect then I am liable to dismissal.

**Name & Address of Own Doctor**

Doc No: QBC.02, Issue Date: 01/02/2024, Issue:2