| Questionnaire | Audio | Spiro | Physical | Drug Screen | Vision |
|---|---|---|---|---|---|

# MEDICAL QUESTIONNAIRE

**Company Name**.....

**Employee:**.....

## PERSONAL HISTORY

| Initials: | | Surname: | |
|---|---|---|---|

| First names: | |
|---|---|

| ID Number | |
|---|---|

| Date of birth | Y | Y | Y | Y | M | M | D | D |
|---|---|---|---|---|---|---|---|---|

.....

| Marital Status: Single | Married | Divorce | Window/Widower |
|---|---|---|---|

| Position | |
|---|---|

| Department | |
|---|---|

| Pre-Employment | | Baseline | | Transfer | | Periodical | | Exit | | Other Specify | |
|---|---|---|---|---|---|---|---|---|---|---|---|

## MEDICAL HISTORY

| | YES | NO | HAVE YOU EVER HAD OR DO YOU NOW HAVE: | YES | NO |
|---|---|---|---|---|---|
| 1.Heart disease or high blood pressure | | | 22.Bleeding from the rectum | | |
| 2.Epilepsy or convulsions | | | 23.Kidney stones or blood in the urine (including Bilharzia) | | |
| 3.Glaucoma or blindness | | | 24.Sugar or protein in the urine | | |
| 4.Family Mellitus (Sugar sickness) | | | 25.Prostate/Gynaecological problems | | |
| 5.Family deaths before 60 years of age | | | 26.Any blood or thyroid disorder | | |
| HAVE YOU EVER BEEN: | YES | NO | 27.Malignant tumours cancer or radiotherapy | | |

| Questionnaire | Audio | Spiro | Physical | Drug Screen | Vision |
|---|---|---|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| 6.Refused live insurance | | | 28.Weight loss (without dieting) | | |
| 7.Refused a driving licence | | | 29.Sexually transmitted disease | | |
| 8.Admitted to hospital(for any reason) | | | 30.Other illness or injuries | | |
| 9.A smoker | | | 31.Allergies : Penicillin etc. | | |
| HAVE YOU EVER HAD OR DO YOU NOW HAVE: | | | 32.Back problems ,joint or bone disease | | |
| 10.Frequent or severe headaches | | | 33.Varicone veins, piles | | |
| 11.Dizziness or unsteadiness | | | 34.Skin disease | | |
| 12.Unconsiousness(for any reason) | | | HAVE YOU EVER : | | |
| 13.Head injury or concussion | | | 36.Had any physical abnormalities | | |
| 14.Epilepsy or fits of any kind | | | 37.Had any surgical operations done | | |
| 15.Any other neurological disorder | | | 38.Abused alcohol | | |
| 16.Any mental/Psychological disorder including | | | 39.Abused drugs or substances | | |
| 17.Eye or vision trouble(except for glasses) | | | 40.Used any medication | | |
| 18.Hearing or speech disorders | | | OCCUPATIONAL HISTORY: | | |
| 19.Hay fever or allergy | | | 41.Asbestos exposure | | |
| 20.Asthma or lung disease | | | 42.Mine or underground work | | |
| 21.Collapsed lung(pneumonia) | | | 43.Chemical exposure | | |

| Comments on Abnormalities: |
|---|
| |
| |
| |
| |
| |
| |

**MEDICAL TRAETMENT WITHIN THE LAST TWO (2) YEARS**

| DATE | NAME OF MEDICAL PRACTITIONER AND MEDICAL SPECIALIST | DIAGNOSIS/REASON FOR TREATMENT |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**GENERAL PRACTIONER OF PREVIOUS TEN YEARS**

| | NAME OF MEDICAL PRACTITIONER | CONTACT DETAILS |
|---|---|---|
| 1 | | |
| 2 | | |

| Questionnaire | Audio | Spiro | Physical | Drug Screen | Vision |
|---|---|---|---|---|---|

**I hereby declare that the above information is correct and I have not provided any misleading information to the company Name & Surname**_____ **Employee Signature**_____

**MEDICAL EXAMINATION CONFIDENTIAL REPORT**

| **Height** | **CM** | **Weight** | **Kg** | **BMI** | |
|---|---|---|---|---|---|

| Has the weight changed by more than 5kg in the past year? | **YES** | | | **NO** | |
|---|---|---|---|---|---|
| If so state a reason | | | | | |

| **Pulse** | **Rate per min** | |
|---|---|---|
| **BP** | **Systolic** | |
| | **Diastolic** | |

**Patient position ……**

**If BP > 140 /90, please repeat after 5 min**

| **Systolic** | |
|---|---|
| | |
| **Diastolic** | |
| | |

**Abnormal BP due to (Not responding to Treatment, Never diagnosed, Defaulted Treatment)**

**……**

**Other……**

**Urinalysis: Are any of the following present in the urine?**

| **Blood** | **Yes** | **No** |
|---|---|---|
| **Protein** | **Yes** | **No** |
| **Glucose** | **Yes** | **No** |

| **Random Glucose** | **mmol/L** | | **Random cholesterol(in indicated)** | **mmol/L** |
|---|---|---|---|---|

**Abnormal Glucose due to (Not responding to treatment, never diagnosed, defaulted treatment)**

| Questionnaire | Audio | Spiro | Physical | Drug Screen | Vision |
|---|---|---|---|---|---|

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| Vision | R | L | Contact lenses used | | Audio | PLH | Spirometry | | Chest X-rays | |
|---|---|---|---|---|---|---|---|---|---|---|
| Far | | | Yes | No | Baseline | | FVC | | | |
| Near | | | Yes | No | | | FVC1 | | | |
| | | | | | | | FVC1/FVC | | | |

| | | Normal | Abnormal | Comments |
|---|---|---|---|---|
| 1 | Eyes , clinical abnormalities | | | |
| 2 | Ear ,Nose, Throat including defect of hearing | | | |
| 3 | Respiratory System | | | |
| 4 | Cardiovascular system including Heart size/sound | | | |
| 5 | Digestive System | | | |
| 6 | Nervous System | | | |
| 7 | Musculoskeletal System | | | |
| 8 | General | | | |
| Lymphadenopathy: Inguinal, auxiliary, Cervical or | | | | |
| Any other circumstances associated with the health record or physical examination which is of importance and not recorded elsewhere in this report? | | | | |
| RECOMMENDATION | Fitness status | | | |
| | Restrictions | | | |
| | Comments | | | |
| | Signature of Nurse | | | |
| | Signature of OHP | | | |
| | Signature OF OMP | | | |

| Questionnaire | Audio | Spiro | Physical | Drug Screen | Vision |
|---|---|---|---|---|---|

## WORKING AT HEIGHTS QUESTIONNAIRE

| Name & Surname | | | |
|---|---|---|---|
| | | | |
| | Main Complaint | | |
| 1. | Have you ever been advised NOT to work at height? | Yes | No |
| 2. | Have you ever had a serious occupational accident or occupational diseases? | Yes | No |
| 3. | Do you have a fear of heights or fear of enclosed spaces? | Yes | No |
| 4. | Do you have, or have you ever had fits/seizures, epilepsy, blackouts, dizzy spells, or episodes of sudden weakness? | Yes | No |
| 5. | Have you ever attempted to commit suicide or have suicidal thoughts? | Yes | No |
| 6. | Have you ever seen a psychologist, psychiatrist or any other health professional for a mental health disease? | Yes | No |
| 7. | Do you often have thoughts that are not own e.g. message from God, the devil or evil spirits? | Yes | No |
| 8. | Do you have a substance abuse problem(alcohol/drugs) | Yes | No |
| 9. | Are you aware of any other problems that could possibly affect your ability to safety perform expected duties and work at heights? | Yes | No |
| 10. | Have you been informed of the tasks you are expected to perform, and the safety requirements and health requirements for working at heights? | Yes | No |
| 11. | Do you have any chronic diseases e.g. diabetes or epilepsy | Yes | No |
| 12. | Additional Comments: | | |
| Examiner: I have explained to the employee that he should notify the supervisor if, at any time, he develops a health condition that he feels may affect his ability to work at height, including the use of medicine. | | Yes | No |
| I .....and ID NO..... i hereby declare that all the Information furnished above is, to the best of my knowledge ,true and correct and that no information has been omitted or withheld. | | | |

**Health Practitioner's Comment:**

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