|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Employee Health General Questionnaire** | | | | |
| **Demographics** | | | | |
| **First Name:** |  | **Nationality:** |  | |
| **Last Name:** |  | **Date of Birth:** |  | **Emp. No:** |
| **Gender:** | □ **M** □ **F** | **Height** (cm)**:** | | **Weight** (kg)**:** |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Occupational History** | | | | | | | |
| No. | From | To | Occupation | No. | From | To | Occupation |
| **1** |  |  |  | **3** |  |  |  |
| **2** |  |  |  | **4** |  |  |  |

|  |  |
| --- | --- |
| **Work Sickness History** | |
| In the past 12 months of your current/last employment, have you been absent from work due to illness and/or injury? | □ yes  □ no |
| If yes, how many days? |  |
| Reason: | |

|  |  |
| --- | --- |
| **Work Exposure (Tick box if yes)** | |
| □ Ionizing Radiation | □ Dust |
| □ Chemicals | □ Noise |
| □ Heavy Meals | □ Industrial Accident |
| □ Other – give details | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Personal History – Do you or have you ever suffered from?**  **(Tick the box if yes)** | | | | |
| Rheumatic Fever | Hemorrhoids/ Rectal Bleeding | Epilepsy | Surgical Operations, specify |
| High Blood pressure | Hernia | Stroke | Have you ever suffered and mental and/or psychiatric illness/disorder? |
| Varicose veins | Jaundice | Migraine | Have you ever taken and/or been prescribed any psychiatric meds? |
| Heart or Blood Disease, specify | Irritable or inflammatory bowel disease: | Multiple Sclerosis | Anemia |
| Respiratory Disease, specify: | Eye Disease, specify: | Thyroid disease, specify | Cancer, specify: |
| Asthma | Ear, Nose, Throat Disease, specify: | Diabetes | Fibromyalgia |
| Peptic Ulcer Disease | Venereal disease, specify | Musculoskeletal Disease, specify | Have you ever suffered any serious head traumas/injuries? |
| Kidney Disease, specify: | Urinary Tract Disease, specify: | Infectious Disease, specify: | Allergies, specify: |
| Other, specify | | | |

□ None of the above Name & Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Females** | | | | | | | | | | | |
| Are you pregnant?□ Yes □ No - If Yes, what is your expected delivery date: ..………………………………………. | | | | | | | | | | | |
| **Family History** | | | | | | | | | | | |
| **Family** | **Alive**  Y/N | | **Age** | **State of Health / Cause of Death** | | | | | | | |
| Father |  | |  |  | | | | | | | |
| Mother |  | |  |  | | | | | | | |
| Brother(s) |  | |  |  | | | | | | | |
| Sister(s) |  | |  |  | | | | | | | |
| **Is there a family history of -** (Tick box if yes) | | | | | | | | | | | |
| Heart Disease □ | | | | | Anemia □ | | Kidney Disease □ | | | | Diabetes □ |
| High Blood Pressure □ | | | | | Asthma □ | | Stroke □ | | | | Cancer □ |
| Allergy □ | | | | | Tuberculosis □ | | Epilepsy □ | | | | Mental Health Disorder □ |
| **Lifestyle** | | | | | | | | | | | |
| Daily consumption of tobacco: per day | | | | | | | Average weekly consumption of alcohol: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Units per week | | | | |
| Exercise type:  Minutes per day:  Times per week: | | | | | | | | | | | |
| **Medical & Surgical History** | | | | | | | | | | | |
| **List all Chronic Health Problems, Hospitalizations and Surgeries that you have experienced:**  I have ***not*** had any chronic health problems, hospitalizations, nor surgeries ***or*** Complete information below □ | | | | | | | | | | | |
| **Date** | | **Problem / Hospitalization**  **/ Surgery** | | | | **Surgery Performed?** | | | | **Current status related to each health**  **issue & date of any surgery**  **performed** | |
| **Yes** | | **No** | |
|  | |  | | | |  | |  | |  | |
|  | |  | | | |  | |  | |  | |
|  | |  | | | |  | |  | |  | |
| **Medication History** | | | | | | | | | | | |
| **Information on Medications taken on a regular or occasional basis over the past two years.**  I have ***not*** taken any medications over the past 2 years ***or*** List as requested below □ | | | | | | | | | | | |
| ***Medication And Dosage*** | | | | | | | ***Date***  ***Started*** | | ***Reason for***  ***Medication*** | | ***Are you currently***  ***taking this medication?*** |
|  | | | | | | |  | |  | | □ Yes □ No |
|  | | | | | | |  | |  | | □ Yes □ No |
|  | | | | | | |  | |  | | □ Yes □ No |
|  | | | | | | |  | |  | | □ Yes □ No |

Name & Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Vaccinations**

Have you ever had any of the following vaccinations or been tested for the following? Please indicate YES, NO or Don’t Know. *\*We recommend that vaccinations 4, 8 & 12 are obtained prior to employment*

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| --- | --- | --- | --- | --- | --- | --- |
|  | **Vaccination/ Test** | **YES** | **NO** | | **Don’t Know** | **Dates / Test**  **results** |
| 1 | Tetanus |  | |  |  |  |
| 2 | Poliomyelitis |  | |  |  |  |
| 3 | Rubella (German Measles) |  | |  |  |  |
| 4 | Varicella (Chicken Pox)\* |  | |  |  |  |
| 5 | TB Test (Heaf, Tine, Mantoux) |  | |  |  |  |
| 6 | BCG (TB Vaccination) |  | |  |  |  |
| 7 | Diphtheria |  | |  |  |  |
| 8 | MMR (Mumps, Measles, Rubella)\* |  | |  |  |  |
| 9 | Influenza |  | |  |  |  |
| 10 | Pneumococcal Vaccine |  | |  |  |  |
| 11 | Hepatitis A |  | |  |  |  |
| 12 | Hepatitis B\* |  | |  |  |  |
|  | - Injection 1 |  | |  |  |  |
|  | - Injection 2 |  | |  |  |  |
|  | - Injection 3 |  | |  |  |  |
|  | - Blood test - AB Titer |  | |  |  |  |
|  | - Booster dose 1 |  | |  |  |  |
|  | - Booster dose 2 |  | |  |  |  |
| 13 | Hepatitis C |  | |  |  |  |
| 14 | Any other |  | |  |  |  |
| 15 | Do you suffer any allergies (including latex) |  | |  |  |  |

|  |  |
| --- | --- |
| Please make sure you have completed all questions on the form.  **Your medical information cannot be evaluated unless all questions are completed or marked “unknown”.** | |
| I confirm that the information and responses I have provided are accurate and true to the best of my knowledge. | |
| ***Signature:*** | ***Date*** *(dd/mm/yy)****:*** |

|  |  |  |  |
| --- | --- | --- | --- |
| ***To be completed by an assigned Medical Doctor*** | | | |
| **Clinical Findings** | | | |
| **Date:** | | **Applicant Number:** | |
| **Applicant Name:** | | **Gender:** | |
| **History reviewed & discussed:** □ Yes □ No | | | |
| **A. Vital Signs:** | | | |
| Blood pressure: Pulse: Respiratory rate: | | | |
| **B. Physical Examination** | | | |
| Height: Weight: BMI (see chart): | | | |
| Head and Neck: | | | |
| Mouth: | | | |
| Nose: | | | |
| Chest and Abdomen: | | | |
| Heart: | | | |
| Upper and Lower Limbs: | | | |
| Spine: | | | |
| Skin: | | | |
| Genitalia: | | | |
| **Declaration** | | | **Signature and Stamp** |
| Physician Name: | Date: | |  |

|  |
| --- |
| **C. Investigation** |
| Audiometry: |
| Vision Test: |
| ECG: |
| Blood Group Test: |
| Biochemistry: |
| Pregnancy Test (for females): |
| Psychiatric Evaluation: Normal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Abnormal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| CBC: |
| Urine Test: |
| Serology for HIV: |
| Serology for Hepatitis C: |
| Serology for Hepatitis B: |
| Chest X-Ray |

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| **Declaration**  **Physician Stamp** |
| I, the signatory declare that from an Occupational Health perspective, this candidate performed the final pre-employment medical screening and the result is:  **\_\_\_\_\_\_\_ FIT \_\_\_\_\_\_\_ UNFIT**  **Dr. Ayman Ahmad**  Medical Director  Date: |

