

MEDICAL HISTORY

NAME: _____
 MARITAL STATUS: _____
 EMPLOYEE ID: _____

JOB TITLE: _____
 SEX: _____
 NRIC/FIN: _____

Please tick (✓) for 'Yes' or 'No' as to whether you had or still have any of the following medical problems:-

	YES	NO		YES	NO
1 Severe headache			15 Asthma		
2 Head Injury			16 High blood pressure		
3 Fainting spells			17 Diabetes		
4 Eye problems / colour blindness			18 TB		
5 Ear ache / deafness			19 Cancer		
6 Chest / lung problems			20 Allergies		
7 Heart problems			21 Deformities since birth		
8 Gastric			22 Fits		
9 Kidney/bladder problems			23 Skin problems		
10 Joint pains					
11 Back aches					
12 Broken bones					
13 Emotional disorder					
14 Frequent colds					

FOR WOMEN ONLY

24 Gynaecological or obstetrical problems		
25 Severe menstrual pains		
26 Are you pregnant		

1 Please explain any 'yes' answer to the above. _____

2 Please explain any other medical problems (not stated above) that you may have.

Please tick (✓) for 'Yes' or 'No' as to the following questions and explain any 'Yes' answers.

1 Are you taking any prescribed medication?
 What kind and for how long? _____

2 Have you been on drugs?
 a.) Were you treated? _____

b.) Are you still addicted? _____

3 Were you ever admitted to hospital?
 When and why? _____

4 Did you undergo any operation before?

Date and reason for operation.

5 Have you been discharged by your previous employers due to poor health?

Date and reason for discharge.

6 Have you been injured in a motor vehicle accident before?

Describe and give date.

7 Have you received workmen's compensation for any work injury or occupational disease?

Please explain and give dates.

8 Have you been rejected for military service?

9 Have you ever had a job where you were exposed to excessive noise, dust, fumers or other conditions which might have an effect on your health? If yes, please give more details.

10 Is there any work you cannot perform for any physical reason?

11 Date of last chest x'ray and where it was taken?

12 Have you been tested for Hepatities?

If yes, are you a carier?

13 Have you been tested for AIDS?

If yes, is your test positive?

Please note: Pre-existing illness will not be covered by our Insurance Company. Please refer to other exclusion in the Benefits Handbook.

I understand that my employment is contingent upon the accuracy of the information given, and it will be used as part of my Medical Report. I hereby certify that all information furnished on this form is true, complete and correct to the best of my knowledge. I understand that if any false statement is made, the Company reserves the right to terminate my employment.

EMPLOYEE'S SIGNATURE

DATE