Pre Medical Questionnaire – Medical In Confidence

Surname	Previous Surname	Title
Forenames	Date of birth	Age Sex M F
Place and Country of Birth	Nationality	Occupation(principal)
Permanent Address	Telephone number Mobile	e-mail
Employer	GP Name & Address & Tel no.	

Do you drink Alcohol? – state average weekly intake	Do you smoke tobacco? Never Date stopped State type, amount & number of years
Do you currently use any medication? State drug, dose, date started and why	

General & Medical history: Do you have, or have you ever had, any of the following? Tick YES or No after each question and elaborate YES answers **overleaf.**

	Y	N		Y	N		Y	N		Y	N
Eye trouble/eye operations			Nose, throat or speech disorder			Malaria or other tropical disease			FAMILY HISTORY OF		
Spectacles and or contact lenses ever worn			Head injury or concussion			A positive HIV test			Heart Disease		
Spectacle/contact lens prescription changed since last medical			Frequent of sever headache			Sexually transmitted disease			High blood pressure		
Hay fever, other allergy			Dizziness or fainting spells			Admission to hospital			High cholesterol level		
Asthma, lung disease			Unconsciousness for any reason			Any other illness or injury			Epilepsy		
Heart or vascular trouble			Neurological disorders Stroke, epilepsy, seizures, paralysis etc						Mental illness		
High or Low blood pressure			Psychological, psychiatric trouble of any sort			Refusal of life insurance			Diabetes		
Kidney stone or blood in urine			Alcohol/drug/substance abuse						Tuberculosis		
Diabetes, hormone disorder			Attempted suicide						Allergy/Asthma Eczema		
Stomach, liver or intestinal trouble			Motion sickness requiring medication						Inherited disorders		
Deafness/ ear disorder			Anaemia/Sickle cell trait/other blood disorders			FEMALES ONLY Gynaecological, menstrual Are you pregnant?			Glaucoma		

Remarks: If previously reported and no change since, so state. **Please write any details overleaf.**

Declaration: I hereby declare that I have carefully considered the statements made above and that to the best of my belief they are complete and correct and that I have not withheld any relevant information or made any misleading statement. I understand that if I have made any false or misleading statement in connection with this application, or fail to release the supporting medical information, that we may withdraw any medical certificate granted.

Date ……..…Signature of Applicant……..Signature of Doctor……..