MEDICAL HISTORY & DECLARATION FORM

Surname _____ Other Names _____ Date of Birth_____

Address & Tel. No. _____ Nationality_____

_____ Occupation_____

Married □ Single □ Separated □ No. of Children □

Please tick ✓ if you have had any of the following:-

□Frequent Colds/Coughs	□Haemorrhoids	□Blood Trouble
□Sinusitis	□Heart trouble	□Skin Trouble
□Ear Infection	□Kidney/Bladder Disease	□Varicose Veins
□Eye Disease	□Sciatica/Lumbago	□Allergies
□Chest Infections/Bronchitis	□Rheumatism	□Major Operations
□Asthma	□Arthritis	□Serious Accident
□Tuberculosis	□Diabetes	□Tropical Disease
□Teeth/Gum Trouble	□Epilepsy/Fits	□Prescribed Medication
□Indigestion/Stomach Trouble	□Headache/Migraine	□Any serious family disease
□Jaundice/Gallstones	□Nervous Complaints	□Other relevant illness

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Do you feel fit for the proposed job? Yes/No
Have you ever been rejected medically? Yes/No
I declare that the above is true and I have not concealed any relevant medical history.

Signature _____ Date _____
If applicable, please ensure that you have a spare set of spectacles/dentures

Name	Date of Birth	Company	Position	Joined Co.

Lab Results		MEDICAL HISTORY		DATE	DESTINATION
Test	Result (+/-)				
Chest X-ray:					
		Toba0cco	Alcohol		
Hepa B & C:		Ht Wt	Gen.: App.:Skin		
		Eyes	$R^{6/}$ $L^{6/}$	Corrected $R^{6/}$	$L^{6/}$
		Ears	Hearing R /20	L /20	
		Nose Throat	Thyroid	Nodes	
HIV/AIDS		Teeth & Gums			
		Heart	Pulse	B.P.	
		Resp. Syst.	Insp.	Exp.	
		Abdomen	Girth		
		C.N.S	G.U.Syst.		
URINALYSIS		Hernia Haemorrhoids		Varicose veins	

REMARKS:

SIGNATURE:.....