

# Farne Salmon and Trout Limited

## Pre-Employment Medical Questionnaire

Please Answer the following Questions and return this form with your application form

(All Information Given Will Be Treated as Strictly Confidential)

The Company reserves the Right to arrange a medical examination for an employee at any time.

Surname:		Forenames:	
Address:			
Own Doctors Name and Address:			
<u>Place of Birth</u>	<u>Date of Birth</u>	<u>Height</u>	<u>Weight</u>

Please answer the following questions ticking the appropriate Yes/No box. If the answer to any question is "Yes" please give details with appropriate dates in the "Remarks" column.			
Have you ever suffered from any of the following	YES	NO	REMARKS
Blackouts, Fainting Attacks or Giddiness			
Epilepsy			
Heart Trouble			
Raised Blood Pressure			
Tuberculosis			
Asthma			
Any other Chest Problems, Such as Periods of Breathlessness, Wheeze, Chest Tightness or Persistent Coughing.			
Do you believe that your chest has suffered as a result of any previous employment			
Any other persistent or history of chest problems			
Mental or nervous Disorders			
Any Known Allergies			
Gastric Disorders and/or Stomach Complaints			
Any Carrier Disease, i.e. Typhoid, Dysentery, Hepatitis.			
Diabetes			
Back Trouble			

<b>Have you ever suffered from any of the following</b>	<b>YES</b>	<b>NO</b>	<b>REMARKS</b>
Do you have or have you ever had any of the following (discount isolated colds, sore throats or flu)			
Recurring Blocked or Running Nose			
Recurring Soreness of or Watering of Eyes			
Foot Trouble			
Varicose Veins			
Migraine			
Ear Infection			
Skin Troubles and/or Rashes			
Rupture			
Are you currently suffering from any form of Human Immunodeficiency Virus (HIV) and/or Acquired Immunodeficiency Syndrome (AIDS)			
Any Other Known Illness			
Is your Eyesight Satisfactory			
If Glasses are worn is your Eyesight Satisfactory			
Are you at present receiving medication prescribed by a doctor (Please list these)			
Do you smoke (if Yes please state amount daily in the remarks column)			
Have you suffered any serious accident, injury or illness			
As a result of the above have you stayed off work and/or school in the past year (if so for how long)			
Have you had a chest x-ray (if so please give date and result if known)			
Are you a Registered Disabled Person			Please give Registration No: and Nature of Disability

I declare that all the foregoing statements are true and complete to the best of my knowledge and belief. I give permission to communicate with my GP or other medical practitioner if appropriate.	
Date:	Signature of Applicant: