



## HEALTH QUESTIONNAIRE

Candidates Name \_\_\_\_\_

Please indicate whether you have suffered from any of the following:

Rheumatism / Arthritis	YES/NO
Frequent Headaches	YES/NO
High Blood Pressure	YES/NO
Gastro-enteritis	YES/NO
Heart Disease	YES/NO
Deafness	YES/NO
Epilepsy	YES/NO
Ruptures	YES/NO
Tuberculosis	YES/NO
Bronchitis or Asthma	YES/NO
Infected ear, nose, throat	YES/NO
Nervous breakdown or mental disorder	YES/NO
Ulcers	YES/NO
Hepatitis B	YES/NO
Are you registered disabled Problems	YES/NO
Have you had a blood test or urine test in the last year?	YES/NO
Have you had any illness in the last six months?	YES/NO
Are you having treatment for any condition at present?	YES/NO
Do you smoke?	YES/NO
Have you had any major operations?	YES/NO

Any other Condition (please detail)

\_\_\_\_\_

\_\_\_\_\_

If you have answered yes to any of these questions please detail down below

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Candidates Signature \_\_\_\_\_

Date \_\_\_\_\_