

**MEDICAL QUESTIONNAIRE**  
**STRICTLY CONFIDENTIAL**

Surname: Mr./Mrs./Miss/Ms. \_\_\_\_\_ All Forenames \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Post Code \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Marital Status \_\_\_\_\_

State if you have suffered from any of the following:

	YES/NO		YES/NO
Tuberculosis		Eating or Mental Disorder	
Blood Coughing		Epilepsy	
Coughing or hoarseness		Sciatica	
of long duration		Genito-Urinary Complaints	
Pneumonia or Pleurisy		Asthma	
Rheumatic Fever (Rheumatism)		Slipped Disc or	
Appendicitis		Back Trouble	
Stomach or Bowel Complaint		High or Low Blood Pressure	
Diabetes		Heart condition/Angina	
Infection of Kidneys		Fainting or Migraine	

Have you ever had any specialist or hospital investigation, X-Ray or E.C.G.? \_\_\_\_\_

Is any investigation pending?  
If so please specify \_\_\_\_\_

Have you suffered an injury?  
If so state when and how \_\_\_\_\_

Are you at present on any form of treatment or medical advice?  
If so please specify \_\_\_\_\_

Have you had any specialist advice in the last two years? \_\_\_\_\_

Have you lost any time through illness or injury in the past three years?  
If so, for what and for how long \_\_\_\_\_

Do you feel in good health \_\_\_\_\_

Have any of your relatives suffered from any of the complaints listed above?  
If so, please state which and the relationship of the person to you \_\_\_\_\_

How much do you smoke per day? \_\_\_\_\_

APPLICANTS SIGNATURE \_\_\_\_\_ DOCTORS SIGNATURE \_\_\_\_\_

Date \_\_\_\_\_ Date \_\_\_\_\_