

HEALTH QUESTIONNAIRE

This form should be completed if the Principal; (i) has been hospitalised for more than 24 hours in the last 3 months, or (ii) has stated 'Poor Health' on a CIP, or (iii) is hospitalised for more than 24 hours during the application process. This information will remain confidential at all times and may effect your application.

(A) PERSONAL HEALTH DETAILS

YOUR NAME:	<input type="text"/>	COMPANY NAME:	<input type="text"/>
DATE OF BIRTH:	<input type="text"/>	DATE THIS FORM COMPLETED:	<input type="text"/>

PLEASE TELL US ABOUT YOUR CURRENT STATE OF HEALTH

IF YOU HAVE BEEN HOSPITALISED FOR MORE THAN 24 HOURS IN THE LAST 3 MONTHS, PLEASE TELL US THE REASON(S):

DATE YOU WERE ADMITTED TO HOSPITAL:	<input type="text"/>	DATE YOU WERE RELEASED FROM HOSPITAL:	<input type="text"/>
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HAVE YOU BEEN ADMITTED TO HOSPITAL MORE THAN ONCE IN THE LAST 3 MONTHS?	YES	IF 'YES' PLEASE PROVIDE DETAILS:	<input type="text"/>
	NO		

ARE YOU CURRENTLY ATTENDING A DOCTOR'S SURGERY OR A HOSPITAL?	YES	IF 'YES' PLEASE PROVIDE DETAILS:	<input type="text"/>
	NO		

ARE YOU CURRENTLY TAKING ANY MEDICATION OR HAVING TREATMENT FROM A DOCTOR OR OTHER MEDICAL PRACTITIONER?	YES	IF 'YES' WHAT TREATMENT OR MEDICINE ARE YOU RECEIVING?	<input type="text"/>
	NO		

HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING?

DEPRESSION, ANXIETY, STRESS-RELATED ILLNESS OR OTHER MENTAL HEALTH ISSUES?	YES	NO
BLACKOUTS, FITS, EPILEPSY OR FAINTS?	YES	NO
HEART PROBLEMS?	YES	NO
DIABETES?	YES	NO
BREATHING DIFFICULTIES SUCH AS ASTHMA?	YES	NO
BACK, NECK OR OTHER PROBLEMS WITH ARMS, LEGS AND JOINTS?	YES	NO
ALCOHOL OR DRUG DEPENDENCY OR MISUSE?	YES	NO

IF 'YES' TO ANY OF THE ABOVE, PLEASE PROVIDE DETAILS:

DO YOU SUFFER FROM ANY MEDICAL CONDITIONS WHICH SIGNIFICANTLY AFFECT YOUR:

SIGHT?	YES	NO
HEARING?	YES	NO
WALKING?	YES	NO
ABILITY TO CLIMB STAIRS?	YES	NO
ABILITY TO BEND?	YES	NO
ABILITY TO LIFT?	YES	NO
STAMINA?	YES	NO

IF 'YES' TO ANY OF THE ABOVE, PLEASE PROVIDE DETAILS:

HAVE YOU EVER BEEN IN CONTACT WITH A SIGNIFICANT INFECTIOUS DISEASE, FOR EXAMPLE HEPATITIS OR TUBERCULOSIS ?

YES
NO

IF 'YES' PLEASE GIVE DETAILS AND DATE(S):

ABOUT YOUR LIFESTYLE

WHAT IS YOUR CURRENT HEIGHT IN CENTIMETRES ?

WHAT IS YOUR CURRENT WEIGHT IN KILOGRAMS?

DO YOU SMOKE ?

YES
NO

IF 'YES' HOW MANY CIGARETTES PER DAY DO YOU SMOKE:

FEWER THAN 10 CIGARETTES PER DAY
10 – 20 CIGARETTES PER DAY
MORE THAN 20 CIGARETTES PER DAY

DO YOU DRINK ALCOHOL ?

YES
NO

IF 'YES', HOW MANY UNITS OF ALCOHOL PER WEEK:

UNDER 5 UNITS PER WEEK
5 – 20 UNITS PER WEEK
MORE THAN 30 UNITS WEEK

DO YOU HAVE ANY DANGEROUS HOBBIES SUCH AS SKYDIVING, ROCK CLIMBING, MOTOR RACING ?

YES
NO

IF 'YES' PLEASE GIVE DETAILS:

HAVE YOU HAD ANY DAYS OFF WORK THROUGH SICKNESS OVER THE LAST 12 MONTHS ?

YES
NO

IF 'YES' PLEASE GIVE DETAILS:

(B) DECLARATION

I hereby swear, under penalty of perjury, that the information provided herein and in any other attached documentation is both true and accurate. I declare that I am in sane mind and of healthy mental order.

Signed:

Dated: