

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: **COMPANY NAME:**

DATE OF BIRTH: **DATE THIS FORM COMPLETED:**

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: **DATE YOU WERE RELEASED FROM HOSPITAL:**

HAVE YOU BEEN ADMITTED TO HOSPITAL MORE THAN ONCE IN THE LAST 3 MONTHS? YES NO IF 'YES' PLEASE PROVIDE DETAILS:

ARE YOU CURRENTLY ATTENDING A DOCTOR'S SURGERY OR A HOSPITAL? YES NO IF 'YES' PLEASE PROVIDE DETAILS:

ARE YOU CURRENTLY TAKING ANY MEDICATION OR HAVING TREATMENT FROM A DOCTOR OR OTHER MEDICAL PRACTITIONER? YES NO IF 'YES' WHAT TREATMENT OR MEDICINE ARE YOU RECEIVING?

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.

Signed:

Dated: