NAME:	

MERIDIAN BUSINESS SUPPORT
THE RECRUITMENT SPECIALIST

Medical Questionnaire. Bring this to the interview. We will help you to complete it.
Aptaujas anketa par veselību. Paņemiet to līdzi uz interviju. Mēs palīdzēsim jums to aizpildīt.
Medicininė apklausos anketa. Atsineškite šią informacinę medžiagą į pokalbį. Mes padėsime jums ją užpildyti.
Ankieta medyczna. Ankietę tę należy zabrać ze sobą na rozmowę rekrutacyjną. Nasza agencja pomoże ją wypełnić.
Медицинская анкета. Возьмите с собой на собеседование. Мы поможем с заполнением.
Zdravotný dotazník. Prineste ho na pohovor. Pomôžeme Vám ho vyplniť

Please answer ALL of the following questions, in order that we may identify those assignments which are most suitable for you to comply with the Working Time Regulations 1998.

	DO YOU SUFFER, OR HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING CONDITIONS	NO	YES In the past but no longer suffering	YES presently	If YES tick if attacks increase at night
1	Impaired Hearing				
2	Ear infection causing discharge				
3	Impaired vision not connected to wearing glasses				
4	Eye Infection including styes				
5	Colour Blindness				
6	Migraine or persistent headaches				
7	Sinusitis				
8	Recurring sore throats				
9	Persistent cough producing sputum				
10	Bronchitis				
11	Hay fever				
12	Asthma				
13	Dermatitis, eczema, psoriasis				
14	Boils or ulcers				
15	Persistent chest pains				
16	Heart disease, heart attack, angina				
17	Unusual shortness of breath on exertion				
18	Faints, dizzy spells, blackouts				
19	Epilepsy				
20	Diabetes (if YES, do you require insulin injections Y/N)				
21	Nervous or mental disorder or depression breakdown				
22	Raised blood pressure				
23	Persistent pain in the joints or arthritis				
24	Severe back or neck pain				
25	Varicose Veins				
26	Rupture or hernia				
27	Glandular trouble eg. Thyroid disorder				
28	Stomach or duodenal ulcers				
29	Frequent indigestion or bowel disorder				
30	Vomiting				
31	Diarrhoea, dysentery, gastro-enteritis, food poisoning				
32	Kidney or bladder infection				
33	Jaundice				
34	Pneumonia or pleurisy				
35	Tuberculosis				
36	Typhoid, para-typhoid, hepatitis				
37	Scarlet or rheumatic fever				
38	Tendosynovitis / Tendonitis				
39	Tennis elbow / golfers elbow				

40	Frozen shoulder or Capsulitis				
41	Problems with muscles, ligaments or tendons in hand or arm				

		NO	YES In the past but no longer suffering	YES presently	If YES tick if attacks increase at night
42	Carpel Tunnel Syndrome				
43	Cervical Spondylosis				
44	Bursitis of the arm				
45	Trigger finger or Vibration White Finger				
46	Aches or pains in your hands, wrists, arms, neck, shoulders or back whilst using a VDU.				
47	Stress or anxiety attacks whilst using a VDU.				
48	Headaches whilst using a VDU				
49	Tired or aching eyes whilst using a VDU				

	PLEASE ANSWER THE FOLLOWING QUESTIONS	**NO**	**YES**	If YES, give details
50	Do you smoke?			(How many per day?)
51	Do you drink alcohol?			(How much per week?)
52	Do you wear glasses?			
53	Have a ever had a chest x-ray?			(When?)
54	Have you suffered illness or injury which required admission to hospital?			
55	Are you presently having treatment from your doctor?			
56	Are you presently taking drugs or medication prescribed or otherwise?			(Are they strictly timetabled Y/N)
57	Are you registered disabled?			(Nature of disability)
58	Have you recently travelled abroad?			(Dates?) (Where?)
59	Are you in good health?			
60	Do you wish to be considered for night work?			
	PLEASE GIVE **NAME & ADDRESS** OF YOUR GP.			

I confirm that the above answers are true to the best of my knowledge and understand that deliberate misrepresentation will result in the termination of my Contract for Services. Should my medical condition change in any respect I will inform Meridian Business Support immediately. I understand that I will be required to update this information on a six monthly basis.

Signature:		Date:	

FOR OFFICE USE ONLY

1 Temporary worker wishes to work nights Yes / No
2 Is temporary worker suitable for night work Yes / No
3 Is temporary worker required for night work Yes / No
4 Will medical assessment be arranged Yes / No

Date arranged for assessment _____ Medical Practitioner _____
(Where applicable)

Result of assessment _____

_____