HEALTH QUESTIONNAIRE - STRICTLY PRIVATE & CONFIDENTIAL

FULL NAME:

HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING

DESCRIPTION	YES	NO	COMMENTS
Heart disease / Chest Pain / Palpitations			
Asthma or Hayfever			
Chronic cough or frequent colds			
Tuberculosis / Pneumonia / Pleurisy			
Bronchitis / Spitting of blood			
Scarlet Fever / Rheumatic Fever			
Swelling of legs or shortness of breath			
High / Low Blood Pressure			
Frequent indigestion			
Frequent Nausea / vomiting			
Recent gain or loss of weight			
Stomach / Liver / Intestinal trouble			
Gall bladder trouble / Gall stones / Jaundice			
Ulcers			
Hernia / Rupture			
Piles / Haemorrhoids / Varicose Veins			
Urinary / Bladder / Prostate trouble			
Sugar / Protein in Urine			
Frequent or painful urination			
Kidney infection / Stone or blood in urine			
Diabetes			
Thyroid or other gland trouble			
Blood or lymph gland disease			
Nervous trouble of any sort			
Mental ilness of any sort			
Epilepsy			
Meningitis			
Paralysis			
Frequent or sever Headaches			
Head injuries			
Dizziness or fainting spells			
Arthritis / Gout or rheumatism			
Painful or swollen joints			
Lack of movement in any joints			
Tenosynovitis			
Foot trouble			
Back trouble / Disc trouble			
Broken bones / dislocations / sprains			
Eye trouble			
Ear trouble / Deafness			
Perforated ear drums or running ears			
Sinus infections			
Acne / dermatitis or other skin disease			
Asin rash from soaps / chemicals / solvents			
Reactions to drugs / infections / medicines			
Any allergies			
Any other matter not covered by the above			

I herewith declare that the above is a true and accurate record of my health.

Signed……. Date…….