Medical Questionnaire

Name:	

Do you or have you suffered, in the last 4 weeks, from the following:	YES	NO
Diarrhoea		
Vomiting		
Infection of Eyes, Ears Nose or Throat		
Infected Wounds, Boils or Acne		
Urinary Infection		
Have you experienced or suffered any symptoms of COVID19 within the last 7 days?		
Persistent Coughing		
Raised temperature/fever		
Loss of Taste or smell		
Have you been in contact with anyone within the last 4 weeks who has suffered from the following?	YES	NO
Diarrhoea		
Food Poisoning		
Gastro-enteritis including Typhoid, Paratyphoid Cholera		

Have you ever suffered from: (Please Tick)	YES	NO
Typhoid Fever, Enteric Fever, Persistent Diarrhoea or infection of the Bowel		
Dermatitis, Eczema, Psoriasis or other skin trouble		
Diabetes, High blood pressure		
Recurrent ear infection, Deafness, problems affecting listening		
Colour Blindness		
Poor eyesight		
Problems affecting standing, walking or use of hands		
Chest Pains, Agina		
Mental Illness, Anxiety, Depression		
Severe Headaches, migraine		
Rheumatism, Arthritis, Fibrositis		
Back trouble, slipped disk		

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Have you ever had any illness/ impairment/ disability which have been caused or made worse by your work? If yes please give details

☐ Yes ☐ No

Are you having or waiting for treatment (including medication) or investigations at present? If yes please give details

☐ Yes ☐ No

Do you think you may need any adjustments or assistance to help you do your job? If yes, please give details

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Declaration

The information I have provided on this form is correct and accurate to the best of my knowledge.

Employee Signature: ______________________________ Date: __________________________

Please inform MTR Group Recruitment of any changes to your details on this form.