**وزارة اﻟﺪﻓﺎع واﻟﻄﯿﺮان واﻟﻤﻔﺘﺸﺔ اﻟﻌﺎﻣﺔ DEFENSE OF MINISTRY**

**GENERAL MEDICAL SERVICES DEPARTMENTS اﻟﻤﺴﻠﺤﺔ ﻟﻠﻘﻮات اﻟﻄﺒﯿﺔ ﻟﻠﺨﺪﻣﺎت اﻟﻌﺎﻣﺔ اﻹدارة**

**NAJRAN ARMED FORCES HOSPITALS PROGRAMME ﺑﻨﺠﺮان اﻟﻤﺴﻠﺤﺔ اﻟﻘﻮات ﻣﺴﺘﺸﻔﻰ ﺑﺮﻧﺎﻣﺞ**

**HUMAN RESOURCE DEPARTMENT MEDICAL QUESTIONNAIRE**

**Applicants should read the following carefully**

The questionnaire below should be completed as fully as possible. All questions must be answered. The information will be treated in strickly confidential

**WARNING:** In completing the questionnaire, you are responsible for the accuracy of your statements. If information is withheld, suppressed, deliberately misleading or false, you may be liable, if employed, to be dismissed.

**NAME : HEIGHT : WEIGHT :** DATE OF BIRTH :

   

|  |  |  |  |
| --- | --- | --- | --- |
| 1**\*** | **Please complete the following:**Do you presently suffer from any illness that requires doctor, hospital or clinic visits? | **YES** | **NO** |
| 2**\*** | Are you currently taking any medications, on a special diet, or physical therapy? |  |  |
| 3**\*** | Have you been hospitalised or had a surgical operation within the last five years? |  |  |
| 4**\*** | Do you have any allergies? |  |  |
| 5**\*** | Have you ever been refused Life Insurance? |  |  |
| 6**\*** | Have you ever received disability payments or been discharged due to ill health? |  |  |
| 7**\*** | Have you had any of the following conditions?**** Hepatitis |  |  |
| **** Cancer   |
| **** Heart or circulatory problems including High Blood Pressure   |
| **** Lung problems including TB   |
| **** Psychiatric problems   |
| **** Neurological problems including migraine or epilepsy   |
| **** Gastrointestinal problems including ulcers, rectal bleeding   |
| **** Diabetes or Thyroid problems   |
| **** Urinary problems   |
| **** Gynaecological problems (females)   |
| **** Arthritis, limb or joint problems   |
| **** Skin problems   |
| 8 | Have you had TB skin testing? |  |  |
| 9 | Have you been immunised against Hepatitis B? |  |  |
| 10 | Is your sight in each eye good enough for all usual activities? |  |  |
| **** Do you wear glasses or contact lenses?   |
| 11 | Is your hearing in each ear good enough for all normal activities? |  |  |
| 12 | Do you smoke? If so, how many per day? |  |  |
| 13 | What was the date of your last medical examination? |  |  |
| 14 | What was the date of your last Chest X-ray? |  |  |
| 15 | How many sick days leave have you had in the past three years? |  |  |

\* **If you have answered yes to any of the above please give a detailed explanation in this section.Use reverse side if necessary.**

**REMARKS**

**I declare that to the best of my knowledge all the foregoing is correct.**

**I fully understand that a health interview or examination may be required.**

Signature: Date:

**I agree that, if required, a medical report may be obtained from my doctor or a specialist. I understand that the report will be treated in confidence.**

Signature: Date:

FORM NO: HR.01 DATE:

12/28/2010

STOCK NO: X

 