To be filled up by the Individual Employee before Pre-Employment Health Check Process

Personal Information

Name :	**Date of Birth :**
Gender :	**Age :**

Read through the following questions CAREFULLY and answer by circling YES / NO:

1	Can you read without glasses?	Yes	No
2	Do you have frequent sneezing/running nose?	Yes	No
3	Do you have frequent bleeding from nose?	Yes	No
4	Do you have decreased hearing?	Yes	No
5	Do you have discharge from the ear?	Yes	No
6	Do you have frequent cough?	Yes	No
7	Do you have frequent wheezing attacks?	Yes	No
8	Have you coughed blood in sputum?	Yes	No
9	Do you have chest pain?	Yes	No
10	Do you have breathing difficulty?	Yes	No
11	Do you tire easily?	Yes	No
12	Do you have palpitations (heart beating fast)?	Yes	No
13	Do you have swelling of you feet or legs?	Yes	No
14	Do you have frequent loose motions (diarrhea)?	Yes	No
15	Do you have recurrent pain in abdomen?	Yes	No
16	Do you urinate frequently?	Yes	No
17	Do you have pain or burning while passing urine?	Yes	No
18	Do you have joint pains?	Yes	No
19	Do you get back pain while standing for a long time?	Yes	No
20	Have you lost interest in eating food?	Yes	No
21	Do you have difficulty in falling asleep?	Yes	No
22	Do you have frequent headaches?	Yes	No
23	Do you have fainting attacks?	Yes	No
24	Have you ever lost consciousness?	Yes	No
25	Do you have any skin disease?	Yes	No
26	Are you allergic to any medicines?	Yes	No
27	Hepatitis B - Incase it is taken, Vaccination date & year	Yes	No

For Female Candidates

27	Do you have a breast lump?	Yes	No
28	Are your menstrual periods regular?	Yes	No
29	Do you have problems related to menstruation?	Yes	No
30	Are you able to carry out normal activities during menstrual periods?	Yes	No
31	Mention the date of your last menstrual period(dd/mm/yy)	Yes	No

-To my knowledge, I have no illness or deformity at this time.

- Note: If you have myopia of more than 3 diopters, you should bring the prescription for your glasses for the last 3 years

-Have you visited any hospital in the past for treatment? - If yes – pls give the reason for hospital visit

-If you are undergoing treatment for any illness currently, please submit all documents of treatment and investigation records for review by medical officer

Past & Present History of Illness for individual :

If you have been diagnosed to have any of the following disease (past or present), write "**YES**" in the box provided against the condition, **otherwise write "NO /NA"**

1	Heart disease		5	Kidney disease	
2	Peptic Ulcer		6	TB	
3	Uses Glass, if yes then the power:		7	Diabetes	
4	Hypertension		8	Mental Disease	
Any other Medical Illness (Specify):					
Any Surgeries (Specify):					
Any Blood borne viral infections (HIV / HBV/HCV eg.):					

3. Family Health Record:

Has anyone in your family suffered/is suffering from any of the following disease?
(Family Members: Father, Mother, Brother, Sister, Grand Parents, Uncle, Aunt)

	Disease			**Relation**
1	Diabetes Mellitus	Yes	No	
2	Hypertension	Yes	No	
3	Tuberculosis	Yes	No	
4	History of Hepatitis B	Yes	No	
5	History of Asthma	Yes	No	
6	Any other illness (Specify)	Yes	NO	

I have gone through the information provided in this sheet and given my consent for conduct of relevant tests mentioned as deemed fit by the Medical Officer.

- If any significant abnormality is found on the health check-up, I am willing to be counseled about this in confidence by the Medical Consultant.
- Any additional investigations, if advised by the Medical Officer will be done by the candidates at his/her own cost.
- I do hereby declare that all the information regarding my health and family health records are true to the best of my knowledge. I have given all the statements correct, including providing additional, supporting information and documentation wherever necessary.
- Any false or incorrect statement or information in connection with this form (my ability, physical or mental health) may lead to a rejection of my employment & make me liable to disciplinary action which may include termination of employment.

Signature of the Employee **Place & Date**:

For Office Use:

Reviewed by Medical Officer (Name): Signature

Date & Time:

Reviewed by HR (Name):

Signature of HR

Date & Time: