Pre-Employment Medical Examination Questionnaire

Personal Information

Full Name

Date of Birth

Gender

Select

Contact Number

Position Applied For

Medical History

Do you have or have you ever had any of the following? (Check all that apply)

- [ ] Diabetes
- [ ] Hypertension
- [ ] Asthma
- [ ] Heart Disease
- [ ] Epilepsy
- [ ] None of the above

Other conditions (specify)

Current Symptoms

Are you currently experiencing any of the following? (Check all that apply)

- [ ] Cough
- [ ] Fever
- [ ] Headache
- [ ] Chest Pain
- [ ] Shortness of Breath
- [ ]

None of the above

Other symptoms (specify)

Lifestyle & Habits

Do you smoke?

Select

Do you consume alcohol?

Select

Allergies

Please list any allergies (e.g., food, medication, environmental)

Medications

Are you currently taking any medications? If yes, please specify

Emergency Contact

Name

Relationship

Contact Number

Declaration

I certify that the information provided above is accurate and complete to the best of my knowledge.

Signature

Date