Occupational Health Medical History Form

Personal Information

Full Name

Date of Birth

Gender

Job Title

Department

Medical History

Have you ever had any of the following? (Check all that apply)

- [ ] Asthma
- [ ] Diabetes
- [ ] Heart Disease
- [ ] High Blood Pressure
- [ ] Epilepsy
- [ ] Allergies
- [ ] Other

Please list any medications you are currently taking

Do you have any disabilities or health conditions we should be aware of?

Work Related Factors

Have you previously suffered any work-related injuries or illnesses?

Are you currently experiencing any symptoms related to your work?

Immunisation History

Please list your immunisations (e.g., tetanus, hepatitis B, etc.)

Additional Information

Is there any other information you would like to share?

Signature

Date