Pre-Employment Health History Update Form

Personal Information

Full Name

Date of Birth

Position Applied For

Contact Number

Email

Health History

Have you had, or do you currently have, any of the following? (Check all that apply):

- [ ] Diabetes
- [ ] Hypertension
- [ ] Heart Disease
- [ ] Asthma
- [ ] Epilepsy
- [ ] Allergies
- [ ] Other

If "Other", please specify:

Have you been hospitalized or undergone surgery in the last 5 years?

- ○ Yes
- ○ No

If yes, provide details:

Are you currently taking any medications?

- ○ Yes

No

If yes, please list:

Do you have any allergies?

Yes

No

If yes, please specify:

Do you have any physical or mental condition that may require workplace accommodation?

Yes

No

If yes, please describe:

Declaration

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

Signature

Date