**MEDICAL IN CONFIDENCE**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **Date:** |  |
| **If Known:** | **NI Number** | **Date of Birth:** | **DD/MM/YYYY** |
|  |  |  |  |  |  |  |  |  |  |
| **Any medical problems?****Detail below** | **YES** | **NO** |
| Are you taking any medication? **If YES give details in comments** |  |  |
| Are you diabetic needing insulin? **If YES give details in comments** |  |  |
| Do you suffer from epilepsy or fits? **If YES give details in comments** |  |  |
| Have you ever had blackouts, recurrent dizziness or any condition, which could cause sudden collapse or incapacity? **If YES give details in comments** |  |  |
| Do you suffer from Asthma? **If YES give details in comments** |  |  |
| Do you suffer from, or have you had any skin problems such as eczema or dermatitis? **If YES give details in comments** |  |  |
| Do you have difficulty hearing normal conversations? **If YES give details in comments** |  |  |
| Do you or have you ever suffered from back pain? **If YES give details in comments** |  |  |
| Do you use handheld power tools or other sources of vibration in your work? **If YES give details in comments** |  |  |
| Have you experienced any hand arm vibration syndrome symptoms: i.e. fingers going white and numb when exposed to cold, tingling hands, loss of grip, sensation or touch? **If YES give details in comments** |  |  |
| **Comments:**(use back of page if required) |
| **NEXT OF KIN (Contact in case of emergency)** |
| Name: |
| Address: |
| Telephone Number: |
| Your Signature: |