

Questionnaire of health condition

All personal data on health condition or other data, as the case may be, become integral part of medical documentation of TeamPrevent s.r.o. after being completed and handed over. This information is confidential, serving for needs of a practitioner of labour medical service.

Name and surname, degree:

.....

Birth identification No: **Phone:**.....

Working position:

1. Have the following diseases occurred with any of your blood relation (parents, grand parents, siblings, children):

- tuberculosis ☐
- diabetes melitus ☐
- malign tumour disease (cancer) ☐
- high blood pressure ☐
- vascular diseases (heart attack, apoplectic seizure) ☐
- asthma ☐
- vein inflammation ☐
- thyroid diseases ☐
- hereditary or inborn diseases ☐
- I am not aware of any of above – mentioned diseases to occur in the family. ☐

2. Have you overcome an attack of any of the following diseases?

- diphtheria ☐
- rubella ☐
- whooping cough ☐
- polio ☐
- scarlet fever ☐
- frequent tonsillitis ☐
- repeated bronchitis ☐
- repeated otitis of middle ear ☐
- I am not aware to have overcome any of the above-mentioned diseases. ☐

3. Have you had any problems with your backbone, have you passed rehabilitation or remedial gymnastics / special physical exercises?

NO ☐

YES ☐ state in detail (e.g. poor posture, scoliosis):

.....

4. Have you any health problems at present?

NO ☐

YES ☐ - What:

.....

5. Have you been treated at present or were you treated in the past for any of the following diseases?

- Infectious diseases (TB,syphilis,gonorrhoea,viral hepatitis,salmonellosis,infecrtious mononucleosis and others) ☐
- Orthopaedics (poor posture of backbone – scoliosis,repeated blockages of backbone,defects in mobility of joints,chronical pains in backbone or joints, _M.Scheuermann) ☐
- Diseases of heart and vessels (myocardial infarction,inflamations in cardiac muscle,including rheumatic fever,disorder in cardiac rhythm,myocardial ischaemia,inborn or acquired cardiac insufficiencies,arterial sclerosis-atherosclerosis) ☐
- Lung diseases(asthma,chronical bronchitis,mediastinal emphysema,frequent viroses or tonsillitis,lung atelectasis/pneumothorax/) ☐
- Nervous diseases (epilepsy,migraine and other paroxysmal conditions, disorders of balance,damages to nervous tissue,damages to senses – sensitivity and mobility) ☐
- Mental illnesses (depressions,manias,psychoses,dependence on alcohol,drug addiction and others) ☐
- Diseases of digestive tract(ulcerous disease of stomach or duodenum,more frequently repeated constipation or diarrhoea and others) ☐
- Diseases of liver and billary tract (fatty degeneration of liver – steatosis, billary colic,gallbladder stones) ☐
- Diseases of pancreas (chronical inflamations and others) ☐
- Diseases of kidneys (chronical inflamations, declining function,colic and others) ☐
- Diseases of urinary tract(inflamations,stones in urinary tract and others) ☐
- Dermatological diseases (eczemas,inflammatory or micotis dermatological diseases) ☐
- Ophtalmic diseases (impaired sight,disorders in field of vision,aftercataract,glaucoma and others) ☐
- Auricular diseases(impaired hearing,chronical inflamations of middle ear,Tinnitus in ears) ☐
- Endocrinology(diseases of thyroid,disorders in level of fats,metabolic diseases,gouty arthritis and others) ☐
- High blood pressure ☐
- Diabetes melitus ☐
- Women:gynaecological diseases ☐
- Other diseases you would like to report to doctor orally ☐
- I am not aware to have been treated for the above-mentioned diseases. ☐

6. Do you suffer from allergies ?

NO ☐ YES ☐ - Provide closer data:

- to drugs –which ones:
- to adhesive tape ☐
- to iodine ☐
- hay,grasses,pollen ☐ mitte,dust,animal hair ☐ foodstuff ☐
- others (state which ones):

What are your manifestations of allergy?Underline:hay fever,conjunctivitis,exanthema,asthma.Others

.....

7. Status of treatment by some of specialised outpatient departments?

Underline: that of cardiology, orthopedics, neurology, dermatology, allergology, diabetology, rheumatology, pulmonary, infectivity, psychiatry, oncology, endocrinology.
Others:

- I am not in care of any specialised outpatient department

☐

8. Have you ever been hospitalised? State when and for what disease.

NO ☐

YES ☐ - What for, when(year):

9. Have you ever had a surgery? For what reason?

NO ☐

YES ☐ - Surgery of what, when(year):

10. Have you ever suffered a more serious injury (fracture, unconsciousness, amputation etc.)?

NO ☐

YES ☐ - What kind, when (year):

11. Do you smoke?

NO ☐ YES ☐ - State how many cigarettes a day:

For what period of time:

12. Do you drink alcohol?

NO ☐ YES ☐ - Underline: regularly-occasionally-exceptionally

13. Do you take addictive substances-drugs?

NO ☐ YES ☐ - What kinds:

How often:

14. Have you been in care of an alcohol or drug rehabilitation advice centre?

NO ☐ YES ☐ - Provide more details:

15. Do you drive a motor vehicle?

NO ☐ YES ☐ - State what groups:

16. Men- Have you done basic military service?

YES ☐ NO ☐ - Was it due to health reasons? (yes/no?):

- What for?

17. Do you take any medication- what kind?

NO ☐ YES ☐ - What kind:

.....

18. Have you been properly vaccinated against tetanus?

NO ☐ I DO NOT KNOW ☐ YES ☐ - The year of the last vaccination

19. Have you ever been in partial or full disability retirement or have you been acknowledged altered capacity to work or occupational disease?

NO ☐

YES ☐ - Provide more details

.....

20. Other facts you consider important:

.....

21. Name, and surname, address of general medical practitioner, with whom you are registered at present:

.....

Affirmation:

To my best knowledge, I declare the information I provided to be true and full. I will report the information I find confidential or personal to the doctor in the course of medical examination. I am aware that, concealing or falsifying important information on my health condition, I assume joint responsibility for possible faulty judgement of my health qualification to work performed. Especially in cases, where disease not stated or intentionally concealed by me can be proven only by specialised examinations that are not common integral part of medical examinations with company practitioner.

Date:

Signature of worker: