

**PUBLIC SERVICE OF NAMIBIA**

**HEALTH QUESTIONAIRE**

**FOR OFFICIAL USE**

Accepted / rejected in accordance with directives

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Post designation : Click here to enter text.

Date: Click here to enter a date.

OMA/RC: Click here to enter text.

**THIS FORM MUST BE COMPLETED BY ALL APPLICANTS**

**A**

|  |  |  |
| --- | --- | --- |
| 1. Surname (in block letters): Click here to enter text. | | Identity No.: Click here to enter text. |
| 2. First Names: Click here to enter text. | | |
| 3. Age (years): Click here to enter text. | 4. Height (cm): Click here to enter text. | Body mass (kg): Click here to enter text. |

**B.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Are you suffering, or have you ever suffered from** | **Mark with a “X” in the appropriate column** | | **If any answer is “Yes”, give details of the nature, severity, date and duration of the illness** |
| Yes | No |
| 1. Any skin disease? |  |  | Click here to enter text. |
| 1. Any condition affecting the skeleton and / or joints? | Yes | No |  |
|  |  | Click here to enter text. |
| 1. Any condition affecting the eyes, ears, nose or teeth? | Yes | No |  |
|  |  | Click here to enter text. |
| 1. Any condition affecting the heart or circulatory system? | Yes | No |  |
|  |  | Click here to enter text. |
| 1. Any condition affecting the chest or respiratory system? | Yes | No |  |
|  |  | Click here to enter text. |

***Please turn over . . . /***

|  |  |  |  |
| --- | --- | --- | --- |
| **Are you suffering, of have you ever suffered from** | **Mark with a “X” in the appropriate column** | | **If any answer is “Yes”, give details of the nature, severity, date and duration of the illness** |
| 1. Any condition affecting the digestive system? | Yes | No |  |
|  |  | Click here to enter text. |
| 1. Any condition affecting the urinary system and / or genital organs? | Yes | No |  |
|  |  | Click here to enter text. |
| 1. Any condition affecting nervous system or mental illness? | Yes | No |  |
|  |  | Click here to enter text. |
| 1. Any other illness? | Yes | No |  |
|  |  | Click here to enter text. |

**C.**

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| * + - 1. Do you have any sensory impairment e.g. hearing, speech or sight? |  |  |
| * + - 1. Do you have any disability?   (physical , mental or any other impairment that substantially restricts you in one or other way of an individual's major life activities)   * + - 1. Any other Disability |  |  |
|  |  |
| **IF YES, GIVE DETAILS OF THE NATURE AND SEVERITY OF THE DISABILITY:**  Click here to enter text. | | |

**D.**

|  |  |  |
| --- | --- | --- |
| Have you undergone any surgery/ operation(s)? | Yes | No |
|  |  |
| **IF YES, GIVE DETAILS OF THE NATURE AND DATE OF THE OPERATION(S)**  Click here to enter text. | | |

**E.**

|  |
| --- |
| I do hereby declare that the above information is true and correct and that I have not withheld any information regarding my health.  .............................................................................................................. ............................................  Signature Date |