

# EMPLOYEE MEDICAL HISTORY

Name .....

Date.....

Have you suffered the following?

- |                               | Yes                      | No                       |
|-------------------------------|--------------------------|--------------------------|
| 1) Industrial dermatitis      | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Noise induced hearing loss | <input type="checkbox"/> | <input type="checkbox"/> |

Have you suffered the following conditions?

- |                                      |                          |                          |
|--------------------------------------|--------------------------|--------------------------|
| 1) Heart condition of any kind       | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Back condition or spinal disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Eye condition requiring attention | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Neurosis or nervous disorder      | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) Hernia                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 6) Injury to arms, legs or feet      | <input type="checkbox"/> | <input type="checkbox"/> |
| 7) Asthma                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 8) Other please state                | <input type="checkbox"/> | <input type="checkbox"/> |

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