MBF Health Declaration Form

MEDICAL HISTORY: Have you ever experienced any of the following:

Eye or vision trouble	Y	N	Diagnosed depression	Y	N
Eye or corneal surgery	Y	N	Anxiety disorder/panic Disorder	Y	N
Hay Fever	Y	N	Learning Difficulty	Y	N
Middle ear infection	Y	N	Attention deficit or hyperactivity Disorder	Y	N
Sinusitis	Y	N	Post traumatic stress disorder	Y	N
Hearing trouble	Y	N	Suicide attempt	Y	N
Any other Ears, Nose & Throat problems or surgery	Y	N	Any other Mental illness	Y	N
Problems with balance	Y	N	Use of legal or illegal recreational drugs or substances	Y	N
Asthma or wheezing	Y	N	Substance dependence or substance abuse	Y	N
Chronic Cough	Y	N	Muscle, bone or joint injury	Y	N
Any other lung problem	Y	N	Back pain, injury or "back trouble"	Y	N
Any shortness of breath	Y	N	Swollen or painful joints	Y	N
Coughed or vomited blood	Y	N	Suffered any pain severe enough to be disabling	Y	N
Pulmonary embolism or deep vein thrombosis	Y	N	Passed blood with or in urine or faeces	Y	N
Any severe allergy	Y	N	Kidney, bladder or prostatic disease	Y	N
Heart problem	Y	N	Easy fatigue-ability or sleep in the day	Y	N
Vascular problem	Y	N	Investigations for abnormal glucose tolerance, high blood sugar, or diabetes	Y	N
Suffered any chest pain	Y	N	Rejection or premium loading for life, health or loss of licence insurance	Y	N
Rheumatic fever	Y	N	Rejection or retirement from employment on medical grounds	Y	N
High or low blood pressure	Y	N	Admission to hospital, psychiatric or in patient facility	Y	N
Severe abdominal pain	Y	N	Taken any type of medicine or alternative medicine for more than 2 weeks	Y	N
Hernia	Y	N	Had a positive laboratory test for HIV infection, or have you suffered from AIDS	Y	N
Oesophagus, Stomach, liver gall bladder or intestinal trouble	Y	N	Sexually transmitted disease	Y	N
Anaemia or blood disease	Y	N	Investigation for any disorder	Y	N
Diagnosed or treated for cancer, tumour, growth or malignancy (including skin cancer)	Y	N	Any major medical or surgical procedure	Y	N
Headaches/migraines which have interfered in any way with daily living?	Y	N	Day surgery	Y	N
Headaches/migraines requiring medication?	Y	N	Any other illness, disability, debility, infirmity treatment or surgery	Y	N
Dizziness or fainting spell	Y	N			
Unconsciousness for any reason	Y	N			
Head injury	Y	N	**Females only:**		
Seizures/fits	Y	N	Any troubling menstrual problems	Y	N
Stroke	Y	N	Other gynaecological problem	Y	N
Paralysis	Y	N	Any obstetric problem	Y	N
Any other neurological disorder	Y	N	Breast lump or other breast problem	Y	N

If you answered "Yes" to any of the above questions, please provide all details of each instance - use extra pages or attach any documents as required

Please turn over for further questions

Has any medical certificate ever been denied, suspended or revoked within or outside of New Zealand?	Y	N
Has any assessment been deferred?	Y	N
Have you ever been identified by a health professional as having a drinking problem, which might include the use of terms such as alcohol abuse, or alcohol dependence?	Y	N
Has a health professional ever expressed concern at your level of drinking?	Y	N
Have you ever received a conviction or formal caution for any alcohol related behaviour including drink driving, public intoxication, or disorderly conduct?	Y	N
Has your alcohol consumption, or behaviour while under the influence of alcohol, ever led to a formal warning or other disciplinary procedure by your current or any past employer?	Y	N
Is any action against you pending, whether by the police or your employer, in respect of any alcohol or drug-related issue?	Y	N
Have you received any Notice under Section 27 of the Civil Aviation Act ? (suspension, restriction, endorsements, etc)	Y	N
Have you at any time been in receipt of a benefit from a loss of licence policy or other disability policy? If so please supply details	Y	N
Is there any other history of illness or health concern which might influence the acceptance of this application?	Y	N
Family History: Have any members of your family had vascular disease, hypertension, diabetes, heart disease, psychiatric disease or neurological disease? (Please mention age)	Y	N

If you answered "Yes" to any of the above questions, please provide all details of each instance - use extra pages or attach any documents as required.

General Practitioner Contact Details:

Address é é é