



CONFIDENTIAL WHEN COMPLETED

**MEDICAL SELF ASSESSMENT FOR
BLUEBELL RAILWAY PLC – FOOTPLATE TASTER DAY PARTICIPANTS**

<i>Name:</i>	<i>Date of Birth:</i>
<i>Address:</i>	<i>Phone Number:</i> <i>e-mail:</i>

It is important to be complete and accurate with your answers to this questionnaire, although trivial matters should be ignored (eg one episode of transient dizziness whilst gardening two years ago).

Tick one box for each question		Yes	No	Don't Know
1	Do you have Diabetes needing Insulin?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	have you ever had Blackouts, fits, epilepsy, fainting attacks, recurrent dizziness, or any condition which may cause collapse or incapacity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Do you get discomfort or pain in the chest, or shortness of breath when exercising – eg when climbing a short flight of stairs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Do you have any difficulty in moving rapidly over short distances, including on slopes, steps or rough ground?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Would you have difficulty in looking over either shoulder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Are you able to meet the legal eyesight standards for driving a car (with glasses or contact lenses, if normally worn)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Do you have any difficulty hearing a normal conversation (with hearing aid(s) if normally used)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Do you have any other impairment of ability to communicate effectively?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Are you taking medication that could give you dizziness or drowsiness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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| 10 | Have you used drugs of abuse (not including alcohol or tobacco) or other substance abuse within the last 12 months? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Tick one box for each question | Yes | No | Don't Know |
| 11 | Have you had any illness related to alcohol in the last 12 months? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12 | Do you have difficulty with or reduction in attention or concentration? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13 | Do you suffer from any mental or nervous disorder (incl. 'nerves')? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14 | Has any doctor advised you to refrain from any work or other activity because of a medical condition, or because of any medication you are taking? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15 | Do you use hearing aid(s)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

The information provided above is complete and correct to the best of my knowledge

<i>Signed:</i>	<i>Date:</i>
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