Certified translation from the Czech language

SOLEMN DECLARATION OF HEALTH CONDITION FOR PURPOSES OF OCCUPATIONAL MEDICINE SERVICES

Name, surname: .....

Date of birth: .....

Birth reg. no.: .....

Address of residence in CZ: .....

Address of permanent residence: .....

Identity Card no.: .....

Passport no.: .....

Health insurance no.: .....

Please circle the appropriate option!

FAMILY MEDICAL HISTORY

Did or does any of your first-degree blood relatives suffer from the following diseases?

tuberculosis, high blood pressure, myocardial infarction, stroke, asthma, epilepsy, hereditary or congenital diseases, other diseases?

□ **NO** □ **YES .....**

PERSONAL MEDICAL HISTORY

Are you currently undergoing any medical treatments? □ NO □ YES .....

Did you undergo any medical treatments in the past? □ NO □ YES .....

LICENCES, RESTRICTIONS

Are you a holder of a firearms licence? □ NO □ YES

Driving licence: □ NO □ YES, groups: .....

Disability pension: □ NO □ YES since .....

degree: .....

Reduced working capacity: □ NO □ YES since .....

Did you suffer from any of the following diseases?

Infectious diseases (TBC, syphilis, gonorrhoea, viral hepatitis, salmonellosis, infectious mononucleosis, other)

□ NO □ YES specify .....

Locomotor system diseases (chronic pain conditions of spine, joints, other ...)

□ NO □ YES specify .....

Cardiovascular diseases (high blood pressure, myocardial infarction, arrhythmia, cardiac disorders, other...)

□ NO □ YES specify .....

Pulmonary diseases (asthma, chronic bronchitis, other ...)

□ NO □ YES specify .....

Nervous system diseases (epilepsy, migraine, coma, balance disorders, other ...)

□ NO □ YES specify .....

Mental diseases (depression, mania, psychoses, alcoholism, drug addition, other ...)

□ NO □ YES specify .....

Digestive tract diseases (ulcer disease of stomach or duodenum, inflammatory intestinal disease, repeated congestion or diarrhoea, other ...)

□ NO □ YES specify .....

Liver diseases and biliary tract diseases (liver fattening disease, gallbladder colic, stones, other ...)

□ NO □ YES specify .....

Kidney diseases and urinary tract diseases (chronic inflammations, reduced functions, colic, stones, other …)

□ NO □ YES specify .....

Skin diseases (eczemas, local allergies, inflammatory or fungal diseases, other ...)

□ NO □ YES specify .....

Eye diseases (reduced eyesight, visual field disorders, heat cataract, glaucoma, inflammations, other ...)

□ NO □ YES specify .....

Ear diseases (reduced hearing, chronic middle-ear inflammations, tinnitus, other ...)

□ NO □ YES specify .....

Endocrinology (diabetes, thyroid gland diseases, fat-level disorders, metabolic diseases, gout, other ...)

□ NO □ YES specify .....

Continuing health care (observance) in a specialized outpatient department (cardiology, diabetology, endocrinology, neurology, psychiatry, ophthalmology, pulmonary department, dermatology, oncology, orthopaedics, allergology, rheumatology, other …)

□ NO □ YES what kind(s) and since when .....

Hospitalization:

□ NO □ YES when and why .....

Operations:

□ NO □ YES specify .....

Injury (fractures, coma, amputation ...)

□ NO □ YES what kind(s) and when .....

Tetanus inoculation:

□ NO □ YES insert the date of last inoculation .....

HARMFUL HABITS

Do you drink alcohol?

□ NO □ YES / Occasionally □ YES/Regularly

□ YES? What kind(s) and how much per day: .....

Do you use any drugs and addictive substances: □ NO □ YES and what kind(s) .....

ALLERGIC ANAMNESIS

Have you had any signs of allergic reactions (especially allergens from the working environment - plastics, metals, paints, dust, pollen or other)

□ NO □ YES specify allergens .....

PHARMACOLOGICAL ANAMNESIS

Do you currently use any medicine?

□ NO □ YES specify.....

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GYNECOLOGICAL ANAMNESIS (*women only*)

Child births: □ NO YES, number .....

Are you pregnant (expectant mother)? NO YES

In your previous jobs, did you work in positions of work categories 2R and higher?

Dust:	NO	YES
Chemical pollutants:	NO	YES
Noise:	NO	YES
Vibrations:	NO	YES
Non-ionizing radiation and electromagnetic field:	NO	YES
Physical stress:	NO	YES
Working posture:	NO	YES
Heat stress:	NO	YES
Cold stress:	NO	YES
Psychological stress:	NO	YES
Eyesight stress:	NO	YES
Biological agents:	NO	YES
Increased air pressure:	NO	YES

Other facts you may wish to add for the physician:

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I declare that to my best knowledge, the information I have provided in this form is true and complete. I will notify the respective physician during the medical check-up of any facts that I consider overly confidential. I am aware that in case I conceal any information or provide false information regarding my health condition, I assume contributory responsibility for any erroneous evaluation of my health fitness to perform the work concerned. This applies chiefly to cases when the diseases I have failed to indicate or I have intentionally denied can be proven only by specialized examinations which are generally not included in medical check-ups performed by company physicians.

I give consent to processing of my personal data according to the GDPR in the sense of Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016.

Dated …… ……

Signature of the person evaluated