

CONFIDENTIAL HEALTH QUESTIONNAIRE

Please answer the following questions, place the completed form in the envelope provided and return it to us with your application form.

If additional information is required, we will contact you directly.

SURNAME **Post Applied For**

FORENAME(s)

ADDRESS **Home Tel No.**

..... **Mobile**.....

..... **Work**

.....

Post Code

Date of Birth

Date of Last Occupational Health Check

Please answer the following questions and return the questionnaire in the envelope provided. No medical details will be divulged without your permission to any person outside the Occupational Health Department, but an opinion about your fitness to work will be given to management.

DO YOU HAVE/HAVE YOU SUFFERED FROM	YES	NO	DATES & DETAILS
1. Sight defect or colour blindness?			
2. Ear/nose/throat problems?			
3. Fits, blackouts, fainting, dizziness?			
4. Frequent headaches/migraines?			
5. Allergies to anything, including latex?			
6. Heart problem?			
7. Circulation problems?			
8. Blood disorders?			
9. High blood pressure?			
10. Asthma?			
11. Recurring chest disease?			
12. Tuberculosis or family history of TB?			
13. Urinary or bowel problems?			
14. Diabetes or thyroid problems?			
15. Eczema or other skin disorders?			
16. Depressive illness requiring treatment?			
17. Digestive problems?			
18. Muscle or joint problems?			
19. Neck/back pain? If YES, have you been referred for this?			
20. Any operations?			
21. Have you been hospitalised (in/out patient)?			
22. Are you currently on any treatment?			

23. Other injuries/illness not mentioned previously?			
24. Details of any extensive travel in the last 5 years?			
25. Do you have any reason to believe you may be infected with HIV/HepB/C?			
26. Do you have health problems which mean you have to take regular time off work?			
27. Any medical condition, which may affect your work?			
28. Do you smoke? How many?			
29. Units of alcohol per week? (1 unit = ½ pint beer = 1 glass wine/sherry)?			
30. Any medical condition, which could preclude you from working night duty?			

Please send a copy of your Hep B & Rubella blood test result

HAVE YOU EVER HAD		DATES
Chicken Pox	Y/N	
Rubella (German Measles)	Y/N	
Pertussis (Whooping Cough)	Y/N	
A positive heaf test	Y/N	

VACCINATION STATUS		DATES
TB	Y/N	
Tetanus	Y/N	
Polio	Y/N	
Rubella		
Hepatitis B	Y/N	
Most recent titre result		

Details of sickness absence from work over the last 2 years? If none, state NONE.

Year No of Days

Year No of Days

Name of GP

Address

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I hereby testify that the answers given on the questionnaire are true to the best of my knowledge an belief. Any false statement on my part may cause my employment to be terminated.

Signed Date