Applicant no.	
Questionnaire ref.no.	

MEDICAL IN CONFIDENCE

Cambridgeshire County Council

PRE-EMPLOYMENT MEDICAL QUESTIONNAIRE

EMPLOYER SECTION

Please complete this section and the table below <u>before</u> issuing to the selected applicant.

Applicant details	Applicant number:
Title Dr/Mr/Ms/Mrs/other:	D.O.B.(dd/mm/yy): / /
Forenames:	Age (Years):
Surname:	Sex : M ☐ F ☐
Address: Postcode:	Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐ Telephone number :
The job	
Position :	School :
Department:	
How many hours will the employee work?	
Fitness for work to be sent to	
Name:	Department: **Education Personnel Management**
Address: **Education Personnel Management** **St John's House** **Spitfire Close** **Ermine Business Park** **Huntingdon** **PE29 6EP**	

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The table below is for completion by the prospective manager. By ticking the relevant boxes in the leftmost column it will clarify to the Occupational Health department those elements of fitness of particular importance to the proposed employment. The Occupational Health department can then advise on any required health surveillance prior to employment.

✓	**Please tick in the first column if the work involves:-**
☐	Regular lifting
☐	Working at heights/on ladders
☐	Confined spaces
☐	Mainly indoors
☐	Sedentary/semi-sedentary
☐	Driving duties
☐	LGV/PSV vehicles
☐	Licensed Taxi
☐	Agricultural/horticulture/gardening work
☐	Regularly outdoors in all weathers
☐	Shift/nights
☐	Work needing hearing protection
☐	Powered vibrating tools
☐	Regular bending
☐	Regular or prolonged standing
☐	Regular walking on uneven ground
☐	Food preparation/catering
☐	Manual cleaning/sweeping/domestic duties
☐	Residential/day care work
☐	Home care work
☐	Work with students/children
☐	Significant use of computers (DES regs.)
☐	Contact with hazardous substances (COSHH regs., includes sewerage, body fluids/blood)
☐	Physical/sport/leisure duties
☐	High mental stress content
☐	Working with challenging behaviours
☐	Working with asbestos
☐	Other (please specify)

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Applicant no.	
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Cambridgeshire County Council

APPLICANT SECTION

Based on your answers to this questionnaire (and your medical if you have one) the Occupational Physician or Occupational Health Nurse will be able to assess whether you are at risk from the work that you may do, or whether you have suffered any problems from work you have done in the past. This information is vital to ensure that any potential risks to your long term health are identified and dealt with. Based on the information you provide, the Occupational Physician or Occupational Health Nurse will issue a certificate of fitness for your proposed employment to the Departmental Personnel Administrator together with any additional recommendations. Incorrect information, or information not provided may invalidate the terms of your employment. The information given on this questionnaire will be used by the Occupational Health department only and will not be given to anyone without your written permission.

Mandatory

Please answer if you have ever suffered or suffer from any of the following diseases or conditions. If so, please state your age at onset or occurrence, and provide any further details in the space provided.

Section 1

	Heart and Circulation	**Yes**	**No**	**Age**	
(a)	Heart attack	☐	☐		
(b)	Angina	☐	☐		
(c)	Other heart disease, or abnormal heart rhythm	☐	☐		
(d)	Chest pain	☐	☐		
(e)	Stroke / mini stroke (TIA)	☐	☐		
(f)	High blood pressure	☐	☐		
(g)	Palpitations	☐	☐		
(h)	Poor circulation, swelling of the legs, deep vein thrombosis	☐	☐		
(i)	Varicose veins, leg ulcers	☐	☐		

Section 2

	Respiratory	**Yes**	**No**	**Age**	
(a)	Shortness of breath, wheezing, troublesome bouts of coughing	☐	☐		
(b)	Regular cough and/or production of phlegm	☐	☐		
(c)	Bronchitis	☐	☐		
(d)	Asthma	☐	☐		
(e)	Any other lung disorder *(If yes, please give details)*	☐	☐		
(f)	Do you smoke?	☐	☐		
(g)	*If no, have you ever smoked?*	☐	☐		
(h)	*If yes how long is it since you stopped?*	Yrs	Mths		
(i)	*Would you like help in giving up?*	☐	☐		

Section 3

	Psychological health	**Yes**	**No**	**Age**	
(a)	Nervous breakdown, panic attacks, phobias, neurosis	☐	☐		
(b)	Psychosis, schizophrenia, obsessive/compulsive disorder	☐	☐		
(c)	Anxiety, depression	☐	☐		
(d)	Stress	☐	☐		
(e)	Eating disorder	☐	☐		
(f)	Have you ever tried to harm yourself?	☐	☐		

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Mandatory

Please answer if you have ever suffered or suffer from any of the following diseases or conditions. If so, please state your age at onset or occurrence, and provide any further details in the space provided.

Section 4

	Eyesight	**Yes**	**No**	**Age**	
(a)	Eye disease, infection, inflammation, bleeding	☐	☐		
(b)	Glaucoma, disease of the retina	☐	☐		
(c)	Do you wear glasses or contact lenses?	☐	☐		
(d)	Have you undergone any eye surgery, or have any planned?	☐	☐		
(e)	Have you ever been prescribed glasses specifically for VDU work?	☐	☐		
(f)	Any other vision defect?	☐	☐		
(g)	Please give the approximate date of your last eye test with an optician (dd/mm/yy)	/ /			

Section 5

	Hearing	**Yes**	**No**	**Age**	
(a)	Are you aware of any hearing problems?	☐	☐		
(b)	Non infective ear disorder	☐	☐		
(c)	Infective ear disease, discharge, glue ear	☐	☐		
(d)	Hearing loss, tinnitus, vertigo, giddiness	☐	☐		
(e)	Ears, nose, throat surgery	☐	☐		

Section 6

	Musculo-skeletal	**Yes**	**No**	**Age**	
(a)	Upper limb – shoulder, elbow, wrist, hand	☐	☐		
(b)	Lower limb – hip, knee, ankle, feet	☐	☐		
(c)	Spine – neck, thoracic, lumbar, spine (e.g. slipped disk, sciatica, recurrent back pain)	☐	☐		
(d)	Muscle or nerve disease (e.g. Chronic Fatigue Syndrome/ME, Fibromyalgia)	☐	☐		
(e)	Arthritis, Gout	☐	☐		
(f)	Muscles or joint problem	☐	☐		
(g)	Fractures, injuries, surgery *(please give details - where, when etc.)*	☐	☐		
(h)	Any other condition or pain? *(If yes, please specify)*	☐	☐		

Section 7

	Skin/nails	**Yes**	**No**	**Age**	
(a)	Skin diseases or conditions (e.g. eczema, psoriasis, dermatitis) *(please give details)*	☐	☐		
(b)	Skin infections, bacterial, fungal (e.g. ringworm)	☐	☐		
(c)	Any occupational skin disorder	☐	☐		
(d)	Skin tumors/cancers	☐	☐		

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Mandatory

Please answer if you have ever suffered or suffer from any of the following diseases or conditions. If so, please state your age at onset or occurrence, and provide any further details in the space provided.

Section 8

	Gastro-Intestinal/Abdominal	**Yes**	**No**	**Age**	
(a)	Hernia	☐	☐		
(b)	Any bowel problems (e.g Colitis, chronic diarrhea, Irritable Bowel Syndrome, crohns, piles/hemorrhoids)	☐	☐		
(c)	Gall stones, pancreatitis,	☐	☐		
(d)	Jaundice or Hepatitis	☐	☐		
(e)	Kidney problems, renal stones	☐	☐		
(f)	Indigestion, stomach, peptic or duodenal ulcers	☐	☐		
(g)	Infections i.e. typhoid, paratyphoid fever, salmonella, cholera etc.	☐	☐		
(h)	Recurring abdominal pains, gynecological problems	☐	☐		
(i)	Problems with appetite or digestion	☐	☐		
(j)	Frequent need for the toilet or incontinence	☐	☐		

Section 9

	Blood/Metabolic disorder	**Yes**	**No**	**Age**	
(a)	Any blood disorder, disorder of lymph glands, anemia, leukemia	☐	☐		
(b)	Any congenital disorder manifested through the blood? *(if yes please give details)*	☐	☐		
(c)	Any disease carried through the blood (e.g. Hepatitis, HIV)	☐	☐		
(d)	Thyroid, pituitary or other hormone disorder	☐	☐		
(e)	Diabetes Mellitus	☐	☐		
(f)	*If yes, do you require insulin injections on a strict timetable*	☐	☐		

Section 10

	Neurological	**Yes**	**No**	**Age**	
(a)	Headaches, cluster headaches, migraines	☐	☐		
(b)	*If yes, please indicate severity(mild, moderate or severe, and how often you get them.*	☐	☐		
(c)	Severe head injury/Concussion	☐	☐		
(d)	Fits, blackouts, fainting, giddy spells, loss of balance, double vision, vertigo	☐	☐		
(e)	Epilepsy *If yes, please give details of last attack (dd/mm/yy)*	☐ / /	☐		
(f)	Any problems with sensation, co-ordination, weakness of muscles etc.	☐	☐		
(g)	Dyslexia	☐	☐		

Sect 11

	General medical	**Yes**	**No**	**Age**	
(a)	Cancer	☐	☐		

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Mandatory

Please answer if you have ever suffered or suffer from any of the following diseases or conditions. If so, please state your age at onset or occurrence, and provide any further details in the space provided.

Section 11

	General medical (continued)	Yes	No	Age	
(b)	Have you ever had a tropical disease? (e.g. malaria)	☐	☐		
(c)	Other illnesses (e.g multiple sclerosis, parkinsons disease etc.) *(please give details)*	☐	☐		
(d)	Do you suffer from any medical condition affecting your sleep? *(if yes please give details)*	☐	☐		
(e)	Are you on a hospital waiting list for investigation or treatment? *(if yes please give details)*	☐	☐		
(f)	Are you attending a hospital, community clinic or seeing a Doctor? *(if yes please give details)*	☐	☐		
(g)	Have you ever had any medical condition not mentioned above that has involved your G.P. a hospital or specialist? *(please give details)*	☐	☐		
(h)	Allergies *(please give details)*	☐	☐		
(i)	Operations *(please give details)*	☐	☐		
(j)	Are you currently taking any tablets or medication or receiving injections? *(If yes, please specify type and timetable)*	☐	☐		
(k)	*(The Occupational Health department is able to offer confidential medical advice and counselling on drug use and giving up)*	☐	☐		
(l)	Do you drink *(If yes, how many units per week? 1 unit = 1 glass of wine or ½ a pint of beer)*	☐	☐		
(m)	Would you consider yourself to be dependent upon or addicted to drugs (medication, recreational or alcohol)	☐	☐		

Section 12

	Vaccinations (please give dates of last vaccination)		
(a)	Tuberculosis (BCG)	/ /	
(b)	Hepatitis A	☐	
(c)	Hepatitis B	☐	
(d)	Initial injection	/ /	
(e)	2nd injection	/ /	
(f)	3rd injection	/ /	
(g)	5 yr booster	/ /	
(h)	Tetanus	/ /	
(i)	Polio	/ /	
(j)	Rubella (Measles)	/ /	

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DISABILITY DISCRIMINATION ACT 1995

It is unlawful to discriminate against disabled people in connection with employment. A person is considered disabled if he or she has a physical or mental impairment which has a substantial and long term adverse affect on their ability to carry out normal day-to-day activities. In order to comply with the Disability Discrimination Act, the company needs to know if you are disabled.

We must inform the Human Resources department if you are disabled, but the details of your disability cannot be provided without your written consent. It may be helpful to the Human Resources department to understand the nature of your disability in order to understand what adaptations may need to be made to the workplace to help you perform your job effectively and to comply with company Health and Safety policies.

Disability	Yes	No	Please give details
Do you have any kind of chronic health condition or disablement?	☐	☐	
Do you believe that this condition or disablement might bring you within provisions of the Disability Discrimination Act 1995?	☐	☐	
When was your condition or disablement first diagnosed	Date:		
Do you consent to the nature of your disability being made available to the Human Resources department to assist them in ensuring that the job is properly fitted to your needs?	☐	☐	
Are there any adjustments or adaptations your employer may need to make to assist you in carrying out your job effectively	☐	☐	
When was your condition or disablement last assessed	Date:		

Your Doctor's Details	Your Specialist/Consultant's Details
GP's name:	Specialist Name:
GP's address: Postcode:	Specialist address: Postcode:
GP's telephone number:	Specialist's telephone number

Signature

Please sign below when you have answered all questions from the mandatory section of the form, and those questions you wish to answer from the optional section of the form.

I certify that I have answered all questions to the best of my ability and knowledge. I understand that withholding information, or knowingly giving incorrect information, about my health on this form may result in disciplinary action or dismissal.

Signed : _____ date (dd/mm/yy) / /

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