



**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 every question )**

**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.**

Heart and Circulation		Yes	No	Age	
(a)	Heart attack	<input type="checkbox"/>	<input type="checkbox"/>		
(b)	Angina	<input type="checkbox"/>	<input type="checkbox"/>		
(c)	Other heart disease, or abnormal heart rhythm	<input type="checkbox"/>	<input type="checkbox"/>		
(d)	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>		
(e)	Stroke / mini stroke (TIA)	<input type="checkbox"/>	<input type="checkbox"/>		
(f)	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>		
(g)	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>		
(h)	Poor circulation, swelling of the legs, deep vein thrombosis	<input type="checkbox"/>	<input type="checkbox"/>		
(i)	Varicose veins, leg ulcers	<input type="checkbox"/>	<input type="checkbox"/>		
Respiratory		Yes	No	Age	
(a)	Shortness of breath, wheezing, troublesome bouts of coughing	<input type="checkbox"/>	<input type="checkbox"/>		
(b)	Regular cough and/or production of phlegm	<input type="checkbox"/>	<input type="checkbox"/>		
(c)	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>		
(d)	Asthma	<input type="checkbox"/>	<input type="checkbox"/>		
(e)	Any other lung disorder <i>(If yes, please give details)</i>	<input type="checkbox"/>	<input type="checkbox"/>		
(f)	Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>		
(g)	<i>If no, have you ever smoked?</i>	<input type="checkbox"/>	<input type="checkbox"/>		
(h)	<i>If yes how long is it since you stopped?</i>			Yrs	Mths
(i)	<i>Would you like help in giving up?</i>	<input type="checkbox"/>	<input type="checkbox"/>		
Psychological health		Yes	No	Age	
(a)	Nervous breakdown, panic attacks, phobias, neurosis	<input type="checkbox"/>	<input type="checkbox"/>		
(b)	Psychosis, schizophrenia, obsessive/compulsive disorder	<input type="checkbox"/>	<input type="checkbox"/>		
(c)	Anxiety, depression	<input type="checkbox"/>	<input type="checkbox"/>		

<b>Mandatory (Please answer every question)</b>				
<b>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.</b>				
(d)	Stress	<input type="checkbox"/>	<input type="checkbox"/>	
(e)	Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	
(f)	Have you ever tried to harm yourself?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Eyesight</b>		<b>Yes</b>	<b>No</b>	<b>Age</b>
(a)	Eye disease, infection, inflammation, bleeding	<input type="checkbox"/>	<input type="checkbox"/>	
(b)	Glaucoma, disease of the retina	<input type="checkbox"/>	<input type="checkbox"/>	
(c)	Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	
(d)	Have you undergone any eye surgery, or have any planned?	<input type="checkbox"/>	<input type="checkbox"/>	
(e)	Have you ever been prescribed glasses specifically for VDU work?	<input type="checkbox"/>	<input type="checkbox"/>	
(f)	Any other vision defect?	<input type="checkbox"/>	<input type="checkbox"/>	
(g)	Please give the approximate date of your last eye test with an optician (dd/mm/yy)	/ /		
<b>Hearing</b>		<b>Yes</b>	<b>No</b>	<b>Age</b>
(a)	Are you aware of any hearing problems?	<input type="checkbox"/>	<input type="checkbox"/>	
(b)	Non infective ear disorder	<input type="checkbox"/>	<input type="checkbox"/>	
(c)	Infective ear disease, discharge, glue ear	<input type="checkbox"/>	<input type="checkbox"/>	
(d)	Hearing loss, tinnitus, vertigo, giddiness	<input type="checkbox"/>	<input type="checkbox"/>	
(e)	Ears, nose, throat surgery	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Musculo-skeletal</b>		<b>Yes</b>	<b>No</b>	<b>Age</b>
(a)	Upper limb – shoulder, elbow, wrist, hand	<input type="checkbox"/>	<input type="checkbox"/>	
(b)	Lower limb – hip, knee, ankle, feet	<input type="checkbox"/>	<input type="checkbox"/>	
(c)	Spine – neck, thoracic, lumbar, spine (e.g. slipped disk, sciatica, recurrent back pain)	<input type="checkbox"/>	<input type="checkbox"/>	
(d)	Muscle or nerve disease (e.g. Chronic Fatigue Syndrome/ME, Fibromyalgia)	<input type="checkbox"/>	<input type="checkbox"/>	
(e)	Arthritis, Gout	<input type="checkbox"/>	<input type="checkbox"/>	
(f)	Muscles or joint problem	<input type="checkbox"/>	<input type="checkbox"/>	
(g)	Fractures, injuries, surgery <i>(please give details - where, when etc.)</i>	<input type="checkbox"/>	<input type="checkbox"/>	
(h)	Any other condition or pain? <i>(If yes, please specify)</i>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Skin/nails</b>		<b>Yes</b>	<b>No</b>	<b>Age</b>
(a)	Skin diseases or conditions (e.g. eczema, psoriasis, dermatitis) <i>(please give details)</i>	<input type="checkbox"/>	<input type="checkbox"/>	
(b)	Skin infections, bacterial, fungal (e.g. ringworm)	<input type="checkbox"/>	<input type="checkbox"/>	
(c)	Any occupational skin disorder	<input type="checkbox"/>	<input type="checkbox"/>	

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(d)	Skin tumors/cancers	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Gastro-Intestinal/Abdominal</b>		<b>Yes</b>	<b>No</b>	<b>Age</b>	
(a)	Hernia	<input type="checkbox"/>	<input type="checkbox"/>		
(b)	Any bowel problems (e.g Colitis, chronic diarrhea, Irritable Bowel Syndrome, crohns, piles/hemorrhoids)	<input type="checkbox"/>	<input type="checkbox"/>		
(c)	Gall stones, pancreatitis,	<input type="checkbox"/>	<input type="checkbox"/>		
(d)	Jaundice or Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>		
(e)	Kidney problems, renal stones	<input type="checkbox"/>	<input type="checkbox"/>		
(f)	Indigestion, stomach, peptic or duodenal ulcers	<input type="checkbox"/>	<input type="checkbox"/>		
(g)	Infections i.e. typhoid, paratyphoid fever, salmonella, cholera etc.	<input type="checkbox"/>	<input type="checkbox"/>		
(h)	Recurring abdominal pains, gynecological problems	<input type="checkbox"/>	<input type="checkbox"/>		
(i)	Problems with appetite or digestion	<input type="checkbox"/>	<input type="checkbox"/>		
(j)	Frequent need for the toilet or incontinence	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Blood/Metabolic disorder</b>		<b>Yes</b>	<b>No</b>	<b>Age</b>	
(a)	Any blood disorder, disorder of lymph glands, anemia, leukemia	<input type="checkbox"/>	<input type="checkbox"/>		
(b)	Any congenital disorder manifested through the blood? <i>(if yes please give details)</i>	<input type="checkbox"/>	<input type="checkbox"/>		
(c)	Any disease carried through the blood (e.g. Hepatitis, HIV)	<input type="checkbox"/>	<input type="checkbox"/>		
(d)	Thyroid, pituitary or other hormone disorder	<input type="checkbox"/>	<input type="checkbox"/>		
(e)	Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>		
(f)	<i>If yes, do you require insulin injections on a strict timetable</i>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Neurological</b>		<b>Yes</b>	<b>No</b>	<b>Age</b>	
(a)	Headaches, cluster headaches, migraines	<input type="checkbox"/>	<input type="checkbox"/>		
(b)	<i>If yes, please indicate severity(mild, moderate or severe, and how often you get them.</i>	<input type="checkbox"/>	<input type="checkbox"/>		
(c)	Severe head injury/Concussion	<input type="checkbox"/>	<input type="checkbox"/>		
(d)	Fits, blackouts, fainting, giddy spells, loss of balance, double vision, vertigo	<input type="checkbox"/>	<input type="checkbox"/>		
(e)	Epilepsy <i>If yes, please give details of last attack</i>	<input type="checkbox"/>	<input type="checkbox"/>		

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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.

(f)	Any problems with sensation, co-ordination, weakness of muscles etc.	<input type="checkbox"/>	<input type="checkbox"/>		
(g)	Dyslexia <i>if yes, please indicate severity(mild, moderate or severe) and what type of Dyslexia</i>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
<b>General medical</b>		<b>Yes</b>	<b>No</b>	<b>Age</b>	
(a)	Cancer	<input type="checkbox"/>	<input type="checkbox"/>		
(b)	Have you ever had a tropical disease? (e.g. malaria)	<input type="checkbox"/>	<input type="checkbox"/>		
(c)	Other illnesses (e.g multiple sclerosis, parkinsons disease etc.) <i>(please give details)</i>	<input type="checkbox"/>	<input type="checkbox"/>		
(d)	Do you suffer from any medical condition affecting your sleep? <i>(if yes please give details)</i>	<input type="checkbox"/>	<input type="checkbox"/>		
(e)	Are you on a hospital waiting list for investigation or treatment? <i>(if yes please give details)</i>	<input type="checkbox"/>	<input type="checkbox"/>		
(f)	Are you attending a hospital, community clinic or seeing a Doctor? <i>(if yes please give details)</i>	<input type="checkbox"/>	<input type="checkbox"/>		
(g)	Have you ever had any medical condition not mentioned above that has involved your G.P. a hospital or specialist? <i>(please give details)</i>	<input type="checkbox"/>	<input type="checkbox"/>		
(h)	Allergies <i>(please give details)</i>	<input type="checkbox"/>	<input type="checkbox"/>		
(i)	Operations <i>(please give details)</i>	<input type="checkbox"/>	<input type="checkbox"/>		
(j)	Are you currently taking any tablets or medication or receiving injections? <i>(If yes, please specify type and timetable)</i>	<input type="checkbox"/>	<input type="checkbox"/>		
(k)	<i>(The Occupational Health department is able to offer confidential medical advice and counselling on drug use and giving up)</i>	<input type="checkbox"/>	<input type="checkbox"/>		
(l)	Do you drink <i>(If yes, how many units per week? 1 unit = 1 glass of wine or ½ a pint of beer)</i>	<input type="checkbox"/>	<input type="checkbox"/>		
(m)	Would you consider yourself to be dependent upon or addicted to drugs (medication, recreational or alcohol)	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Vaccinations (please give dates of last vaccination)</b>					
(a)	Tuberculosis (BCG)		/	/	
(b)	Hepatitis A	<input type="checkbox"/>			
(c)	Hepatitis B	<input type="checkbox"/>			
(d)	Initial injection		/	/	
(e)	2 <sup>nd</sup> injection		/	/	

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(f)	3 <sup>rd</sup> injection	/	/	
(g)	5 yr booster	/	/	
(h)	Tetanus	/	/	
(i)	Polio	/	/	
(j)	Rubella (Measles)	/	/	

**To be completed by applicant****EQUALITY ACT 2010**

It is unlawful to discriminate against disabled people in connection with employment. A person is considered disabled if they have 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 Equality Act your prospective employer needs to know if you have a physical or mental impairment which may be considered a disability within the Act.

It may be helpful for your employer to understand the nature of your disability in order to consider what adjustments may need to be made to the workplace to help you perform your job effectively and to comply with Health and Safety. You do not have to disclose the nature of your disability on this form, however if you are not required to complete Part 2A of the pre-employment forms (which will provide Occupational Health with information enabling them to advise your employer) and you do not provide any information on this form, your employer will not be able to consider any adjustments to your working environment.

Disability	Yes	No	Please give details
Do you have any kind of chronic health condition or disablement?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you believe that this condition or disablement might bring you within provisions of the Equality Act 1995?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	
Are there any adjustments or adaptations your employer may need to make to assist you in carrying out your job effectively	<input type="checkbox"/>	<input type="checkbox"/>	
When was your condition or disablement last assessed	Date:		

Your Doctor's Details	Your Specialist/Consultant's Details (1)
GP's name:	Specialist Name:
GP's address:	Specialist address:
Postcode:	Postcode:

GP's telephone number:	Specialist's telephone number
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<b>Your Specialist/Consultant's Details (2)</b>	<b>Your Specialist/Consultant's Details (3)</b>
Specialist Name:	Specialist Name:
Specialist address:	Specialist address:
Postcode:	Postcode:
GP's telephone number:	Specialist's telephone number

**To be completed by applicant****GP REPORT**

It may be necessary for Heales Medical Ltd to obtain further information from your GP or Consultant before they are able to determine your fitness for work. Any reports provided will form part of your Occupational Health Medical records and will not be provided to your employer. Under the 'Access to Medical Reports Act 1998' a medical report cannot be provided by a Medical Practitioner without your consent. You have the following options regarding any report requested:-

1. You may withhold your consent to a report being provided to us.
2. You may consent, but request to see the report before it is provided to us. The Medical Practitioner will then send the report to you. If you have not replied to them within 21 days of the report being sent, they may assume consent and provide the report to us. If you do not approve the report due to any information you deem incorrect, you can request in writing, that the report be amended. The Medical Practitioner may or may not agree to amend the report. If they do not you may:-
  - a) withdraw your consent to the report being issued
  - b) request that the Medical Practitioner attach a statement from yourself to the report
  - c) agree to the report being issued unchanged

You may also withdraw your consent to the report being provided if the Medical Practitioner declines to show you the report, or part of the report, if they consider there are special circumstances as described in the Act.

3. You may consent to the report being provided (and request a copy if you wish – up to 6 months after it has been provided).

Heales Medical Ltd will inform you of each report that is requested.

I do not consent to a medical report being provided to Heales Medical Ltd	<input type="checkbox"/>
I consent to a medical report being provided to Heales Medical Ltd, but I wish to see it before it is issued.	<input type="checkbox"/>
I consent to a medical report being provided to Heales Medical Ltd	<input type="checkbox"/>
If you require a copy of the report/s please ask your GP or Specialist, please not you may be charged	

Signed :

Date (dd/mm/yy) :

/ /

**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) / /
Print Name:	

**Now that you have completed the whole form, please return it in the envelope provided**