HEALTH QUESTIONNAIRE

All Hospitals will require a health questionnaire from you. The information given is confidential. Please ensure it is completed fully.

Surname		Title	Gender M / F
Forename		Date of Birth	
Maiden Name		National Insurance No.	
Home Address		Postcode	

Please indicate if you have had the following vaccinations/tests

Vaccination	Date	Result
Polio		
Rubella		
Varicella		
Diphtheria		
BCG Do you have a BCG scar? YES/NO		
Heaf Test		
Tetanus		
Typhoid		
MMR		
Hepatitis A		
Hepatitis B		
1st		
2nd		
3rd		
Titre		
Booster		

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Please answer all of the following questions. If you answer yes please give details in the space provided on next page.

		Yes	No
1	Do you have any eyesight problems not corrected with spectacles/ contact lenses?		
2	Do you have any problems hearing a conversation or using the telephone?		
3	Do you have any special needs to help you do your job?		
4	Do you have any problems with your hands, arms, legs or feet which affect movement or normal use?		
5	Do you have any difficulty in sitting, standing, bending or lifting?		
6	Have you ever had any kind of back and/or neck problem?		
7	Have you ever had any kind of problem with your joints including pain, swelling or stiffness?		
8	Have you any medical condition that may affect you immune system eg. HIV/AIDS?		
9	Have you ever had blood disorders or hepatitis?		
10	Do you have diabetes?		
11	Are you waiting for any treatment or investigation?		
12	Have you ever had dry/irritated skin affecting your hands?		
13	Have you ever had any kind of skin problem?		
14	Have you ever had any mental health or psychological problems eg. anxiety, depression, stress, eating disorder?		
15	Have you ever had a problem with alcohol or substance/drug use?		
16	Have you ever had any seizure, fit or blackout?		
17	Do you have any allergies eg. to nickel, latex (rubber) or any other substances?		
18	Have you ever had asthma, bronchitis or chest problems?		
19	Have you or any member of your family ever had Tuberculosis (TB)?		
20	In the past 12 months have you had a cough for more than 3 weeks, coughed up blood or had any unexplained loss of weight, fever or night sweats?		
21	Have you seen a doctor or any other health professional in the last 2 years for any kind of health problem?		
22	Are you having any treatment, medications/investigations or have you had any in the past 2 years?		
23	Have you had Health surveillance in previous employment?		
24	Have you had any time off work due to sickness during the past 2 years?		
25	Have you ever had any illness/injury that may have been caused or made worse by your work?		
26	Have you been retired or had to leave work on the grounds of ill health or injury?		
27	Do you have any current/recurring health condition/disability, which might affect your ability to do the proposed job?		

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Use this section to provide further information on any questions to which you have answered "Yes"

Details which may be useful, include:

a) How long have you had this problem?
b) What type of treatment, if any, did/do you receive?
c) Were you admitted to hospital, unable to work or prevented from carrying out your normal activities because of the problem?
d) Does the condition continue to affect you in any way?
e) Do you think that you need any adjustments or changes to the job/workplace, for which you have applied?

Question Number	Details

Employee Declaration

I declare that the information I have given is true and complete to the best of my knowledge and belief. I understand that the accuracy of this declaration is important to enable assessment of my ability to carry out the duties of this post, and to ensure that taking up the post will not be detrimental to my health. I also understand that it is important for me to give a complete account of any health problems, to allow any disabilities that I may have to be taken into consideration, and to enable reasonable adjustments to be made in the workplace.

Signature _____ Date_____

Please print full name _____

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