

## Pre Employment Health Questionnaire

Personal Details		
Title:	Surname	Forenames
Date of Birth		
UK Address		
Postcode	Tel. Number	Mobile
GP Name	GP Tel. Number	
GP Address		

Declaration of Health			
Immunisations			
	Date	Hepatitis B Injections	1st Date
Rubella	Yes / No	2nd Date	3rd Date
BCG	Yes / No		
Skin Test or TB	Yes / No	Booster	1st Date
Tetanus	Yes / No	2nd Date	3rd Date
Poliomyelitis	Yes / No		
Diphtheria	Yes / No	Date of last blood test	
Are you immune to Measles?	Yes / No		
Are you immune to Mumps?	Yes / No	Titre Results	
Have you had Chickenpox?	Yes / No		
Other, please specify		Date	

Pregnancy at work regulations
To protect your health at work please indicate in confidence to a member of staff if you are pregnant or breast feeding

Further medical questions
Weight: _____ Height: _____
On the next page you are asked to provide information about a variety of conditions, please describe any other ill health circumstances
Are you at present taking any medication or receiving any treatments? Give details for the last 12 months
Please give details of sickness absence for the last 2 years

Have you ever had problems with:	Yes	No	Please give details	Recovery complete	Yes	No
Blood Disorders or raised blood pressure	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Heart or circulatory problems	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Chest complaints eg Asthma, Bronchitis, Pleurisy, Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Chronic indigestion, bowel complaints, or persistent abdominal pains	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Are you HIV positive, or at increased risk due to lifestyle?	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Are you hepatitis C positive?	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
If yes, are you aware of the NHS guidelines and willing to comply with them?	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Liver disease or jaundice	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Diabetes, problems with thyroid or other glands	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Kidney or bladder problems	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy, Blackouts or dizziness	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Any mental health problems, including depression, psychiatric treatment, eating disorders or attempted suicide	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Have you received or are you receiving counselling	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Substance misuse including alcohol	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Persistent or recurrent backache or injury	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Neck injury / problems with neck	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Eczema, Dermatitis or other skin disease (Latex allergy)	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Ear, nose or throat problems	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Rheumatism, Arthritis or other joint problems	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Vision problems or eye disease	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Hay fever or allergies	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Any other serious illness	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Any operations	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Admission to hospital	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Serious accidents / visits to casualty. If YES how many times have you attended a casualty department in the last 3 years?	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
<b>Note: If there is a possibility that you may be suffering from an infection, you are required to discuss this - in confidence with a member of the branch staff before taking up employment.</b>						

Declaration		
I declare that I am fit for work and that all information is correct and accurate to the best of my knowledge.		
Signature:	Name:	Date:

For office use only		
1. Fit without restrictions	<input type="checkbox"/>	3. Needs GP/specialist report <input type="checkbox"/>
2. Fit with restrictions (see below)	<input type="checkbox"/>	

Restrictions / comments		
1. Needs to clarify Hep B status	<input type="checkbox"/>	4. Latex allergy <input type="checkbox"/>
2. Advise see GP/Practice Nurse	<input type="checkbox"/>	5. Other allergies <input type="checkbox"/>
3. Needs to complete GP Authorisation Form (see HR Manual)	<input type="checkbox"/>	

RGN Co-ordinator		
Signature:	Name:	Date:
Need for referral <input type="checkbox"/>	To whom:	Date to review: