Wribbenhall School

Medical Questionnaire

This questionnaire is to be treated as **medical in confidence.** Please tick boxes and give full information as appropriate. If necessary, attach additional paper.

**please return the completed questionnaire to wribbenhall school** marked **medical in confidence**

# personal details

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Surname: |  | | | | First Name[s]: |  |
| Mr/Mrs/Miss/Ms/Other: | | |  | | Date of Birth: |  |
| Home Address: | |  | | | |  |
| Post Code: | |  | | | Telephone No: |  |
| GP: | |  | | | Telephone No: |  |
| Surgery Address: | |  | |  | |  |
| Next of Kin Name: | |  | | Relationship to you: | |  |

# new employer

|  |  |  |  |
| --- | --- | --- | --- |
| Company: |  | Contact Name: |  |
| Work Location: |  | Department: |  |

# employment

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Type of medical assessment: | | New Starter | |  | | | | |  | | |
| Job Title: |  | | | If not new starter, how Long with Present Employer? | | | | | | |  |
| Previous Job 1: | | | |  |  | | | | | | |
| Previous Job 2. | | | |  |  | | | | | | |
| Previous Job 3. | | | |  |  | | | | | | |
| **Work Hazards in new employment.** | | | |
| Do any of the following apply to your proposed or current employment? | | | | | | | | | | | |
| Keyboard Use | | | Heavy Lifting | | | Physically Strenuous | | | | Eye Hazards | |
| Stressful Work | | |  | | | Driving Duties | | | | Working at Heights | |
| Skin Irritants or Sensitisers | | | Respiratory Hazards | | | Shift Work | | | | Infectious Diseases | |
| Noise | | | Vibrations | | | Lift Trucks | | | | Food Handling | |
| Confined Space | | | Others [please specify] | | | |  |  | | | |
| List any hazards that apply from any previous employment: | | | | | | | |  | | | |
|  | | | | | | | |  | | | |

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| --- | --- | --- |
| fitness for work | **yes** | **no** |
| Do you have any medical condition that affects your fitness for work? If YES, please give details. |  |  |
|  |  |  |
|  |  |  |
| Have you ever had to give up a job for medical reasons? If YES, please give details. |  |  |
|  |  |  |
|  |  |  |
| Do you require any special adjustments to be made in order to do the type of work you undertake? If YES, please give details. |  |  |
|  |  |  |
|  |  |  |
| Have you been absent from work due to sickness for more than 10 days during the past 12 months? If YES, please give details. |  |  |
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| Do you have a chronic chest disorder where night-time symptoms may be a particular problem? If YES, please give details. |  |  |
|  |  |  |
|  |  |  |
| Do you have a stomach or intestinal disorder where the timing of a meal is particularly important? If YES, please give details. |  |  |
|  |  |  |
|  |  |  |
| Do you have a heart or circulatory disorder that affects your physical stamina? If YES, please give details. |  |  |
|  |  |  |
|  |  |  |
| Do you suffer from diabetes that requires insulin injections on a regular basis?  If YES, please give details. |  |  |
|  |  |  |
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| --- | --- | --- |
| your health | **yes** | **no** |
| Have you consulted your GP or a hospital specialist in the past 6 months? If YES, please give details. |  |  |
|  |  |  |
|  |  |  |
| Are you currently taking prescribed medication? If YES, please give details. |  |  |
|  |  |  |
|  |  |  |
| Do your have any allergies? If yes, please give details |  |  |
|  |  |  |
|  |  |  |
| Do you smoke? YES/NO. If YES, what, and how many: |  |  |
| Are you an ex-smoker? YES/NO. If YES, years/months since stopped. |  |  |
| Do you drink alcohol? YES/NO. If YES, how many units per week? |  |  |

# medical history

Do you now have or have you ever had any of the following?

|  |  |  |
| --- | --- | --- |
| Heart Problems | Chest Disease/TB |  |
| Kidney Disease | Gastric/Duodenal Ulcer |
| Bowel Disease | High Blood Pressure |
| Asthma | Diabetes |
| Faints/Blackouts | Back Pain |
| RSI | Depression/Anxiety/Stress |
| Partial/complete blindness | Colour Blindness | |
| Hearing Deficiency | Disease affecting the joints | |
| Sleep Disorder | Skin Condition | |
| Severe Headache/Migraine | Epilepsy | |
| Hernia | Any surgical operations | |
|  | Any other **significant** condition | |
| If you have ticked any box, please give full details here: | | |
|  | | |
|  | | |
|  | | |
|  | | |
|  | | |

**I hereby declare that all medical information given by me to Wribbenhall School is true and accurate to the best of my belief and knowledge.**

**I further declare that I do not omit or falsify any material, facts, or details, which could have a bearing on my state of health.**

**Consent:**

**I agree to all relevant personal data being processed and stored by Wribbenhall School. The personal information will be stored in accordance with the General Data Protection Regulations 2018 and the TOHS Privacy Policy.**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Signature |  |
| Date: |  |  |  |

School Use Only:

I certify that the above person is deemed

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Fit for current position |  |  | Unfit for current position | |  |  |
|  |  |  |  |
| Should be Referred to OH Physician: |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Signed: |  | Dated: |  |
|  | Proprietor (or representative) |  |  |