

# HEALTH QUESTIONNAIRE

## Applicants should read and complete the following form carefully

All questions must be answered fully. All information provided will be treated confidentially.

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| * NAME : |  | | | | **Yes** | **No** |
| * Do you smoke? | | | | |  |  |
| * Do you wear glasses or contact lenses? | | | | |  |  |
| * Is your sight in each eye good enough for usual activities with glasses/contact lenses if necessary? | | | | |  |  |
| * Is your hearing in each ear good enough for all normal activities including telephone? (with hearing aid if necessary) | | | | |  |  |
| * Have you ever had any operations or been admitted to hospital? | | | | |  |  |
| * Are you currently attending any hospital, clinic or outpatient department? | | | | |  |  |
| * Have you ever resigned a job because of ill health? | | | | |  |  |
| * Do you have any symptoms, which prevent you from going to work? | | | | |  |  |
| * Are you or have you ever been registered Disabled? | | | | |  |  |
| * Is your vaccination status up to date with regards to TB (BCG) and Hepatitis B immunisation?   ***(Evidence will be required at a later date)*** | | | | |  |  |
| * What is your BMI (Divide your weight by your Height squared) | | | | |  | |
| **Have you ever suffered from:** | |  | | |  |  |
|  | | **Yes** | **No** |  | **Yes** | **No** |
| 1. Fainting attacks & giddiness | |  |  | 14. Tuberculosis |  |  |
| 1. Sinusitis | |  |  | 15. Bronchitis |  |  |
| 1. Hepatitis | |  |  | 16. Diabetes |  |  |
| 1. Recurring Headaches/Migraines | |  |  | 17. Dermatitis or other skin disorders |  |  |
| 1. Foot or Knee trouble | |  |  | 18. Varicose veins causing trouble |  |  |
| 1. Kidney or bladder disease | |  |  | 19 .Back/Neck trouble, Sciatica/Arthritis |  |  |
| 1. Blackouts, Epilepsy or fits | |  |  | 20. Heart trouble, Heart Attack or Angina |  |  |
| 1. Raised Blood Pressure | |  |  | 21 .Gynaecological Problems |  |  |
| 1. Asthma | |  |  | 22. Psychiatric – Disorders / Depression / Breakdown |  |  |
| 1. Latex allergy diagnosis | |  |  | 23. Chemical Sensitivities |  |  |
| 1. Occupational overuse syndrome/repetitive strain injury | |  |  | 24. Have you been exposed to MRSA in the last 6 weeks? |  |  |
| 1. Are you at present having any treatment prescribed by a doctor? | |  |  | 25. In the last two years, have you been off work because of illness or injury? |  |  |
| 1. Renal Condition, HIV or other immuno-suppressive illnesses | |  |  | 26. Do you have, or have you had any defect, disorder, or any other condition, mental or physical not already mentioned in one of your answers? |  |  |

**If you have stated YES to ANY question in the above table, please state question number and give details, dates, time lost at work and any treatment provided / being provided? (Use reverse side if insufficient space)**

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The information given above is correct as far as I am able to confirm at the date of signing, and I do not suffer from any other clinical or medical conditions. I am willing for any employer to contact either my GP or Occupational Health Unit at my current employment to discuss any aspect of my health record.

The name and contact telephone number of my GP is:Steve Phillips Martinborough Wairarapa

I give my permission for Medacs Healthcare to present the information on this form to any potential employers.

Name:       Signature:  Date: