Health Questionnaire Staff

NEW EMPLOYEE MEDICAL QUESTIONNAIRE - CONFIDENTIAL

The purpose of the questionnaire is to see whether you have any health problems that could affect your ability to undertake the duties of the post you have been offered or place you at any risk in the workplace. We may recommend adjustments or assistance as a result of this assessment to enable you to do the job. Our aim is to promote and maintain the health of all people at work. Before health clearance is given for employment, you may be contacted by the Healthier Business UK Ltd and may need to be seen by an occupational health advisor or physician. Your record will be held on file for a short period of time and may be subject to audit. Your file may also be used to cross-reference and should be registered on our system by one employer.

Details		
Title (Mr/Miss/Mrs/Ms/Mx):	**First names**:	
Surname:	**Date of Birth**:	
Work Tel:	**Home Tel**:	**Mobile**:

Medical History		
All staff groups complete this section	**Yes**	**No**
Do you have any illness/impairment/disability (physical or psychological) which may affect your work?		
Have you ever had any illness/impairment/disability which may have been caused or made worse by your work?		
Are you having, or waiting for treatment (including medication) or investigations at present? If your answer is yes, please provide further details of the condition, treatment and dates.		
Do you think you may need any adjustments or assistance to help you to do the job?		
If you have indicated yes to any of the above questions, you must provide further details - failure to do so will result in the form being returned/rejected.		

Home Address		GP Address	

All staff groups complete this section	Yes	No
Do you have any illness/impairment/disability (physical or psychological) which may affect your work?		
Have you ever had any illness/impairment/disability which may have been caused or made worse by your work?		
Are you having, or waiting for treatment (including medication) or investigations at present? If your answer is yes, please provide further details of the condition, treatment and dates.		
Do you think you may need any adjustments or assistance to help you to do the job?		

Additional Information
(If you have answered yes to any questions above please provide additional information below)

Tuberculosis

Clinical diagnosis and management of tuberculosis, and measures for its prevention and control (NICE 2006)	Yes	No
Have you lived continuously in the UK for the last 5 years?		
If you answered no above, please list below all of the countries that you have lived in over the last 5 years:		
Have you had a BCG vaccination in relation to Tuberculosis?		
If you answered yes please state when: Date		
Do you have any of the following:		
A cough which has lasted for more than 3 weeks.		
Unexplained weight loss.		
Unexplained fever.		
Have you had tuberculosis (TB) or been in recent contact with open TB?		

Additional Information
(If you have answered yes to any questions above please provide additional information below)

Chicken Pox or Shingles

	Yes	No	Date
Have you ever had chickenpox or shingles?			

Immunisation History

Have you had any of the following immunisations:	Yes	No	Date
Triple vaccination as a child (Diptheria / Tetanus / Whooping cough).			
Polio.			
Tetanus.			
Hepatitis B (If Yes is ticked please give dates below).			

Course	1		2		3	
Course	1		2		3	

Proof of immunity (please send the following)

Varicella	You must provide a written statement to confirm that you have had chickenpox or shingles however we strongly advise that you provide serology test results showing varicella immunity
Tuberculosis	We require an occupational health/GP certificate of a positive scar or a record of a positive skin test result (Do not Self Declare)
Rubella, Measles & Mumps	Certificate of “two” MMR vaccinations or proof of a positive antibody for Rubella Measles & Mumps
Hepatitis B	You must provide a copy of the most recent pathology report showing titre levels of 100lu/l or above

Proof of Immunity (Please send the following) EPP Candidates Only

Hepatitis B Surface Antigen	Evidence of a negative Surface Antigen Test Report must be an identified validated sample (IVS).
Hepatitis C	Evidence of a negative antibody test Report must be an identified validated sample (IVS).
HIV	Evidence of a negative antibody test Report must be an identified validated sample (IVS).

Exposure Prone Procedures

	Yes	No
Will your role involve Exposure Prone Procedures?		

Have you ever had or suffered from:	**Yes**	**No**
Epilepsy/Blackouts		
Nervous Mental Disorders		
Migraine/Headaches		
Sensory Impairment		
Skin Allergies		
Back pain/Previous Back Injury		
Heart Condition		
Asthmatic or respiratory ailments		
Recurring Incidence of Illness		

Proof of Immunity (Please send the following) EPP Candidates Only

Please List below any covid-19 vaccinations or immunisations:	
Date	
Immunisation	
Expiry	
Date	
Immunisation	
Expiry	
Date	
Immunisation	
Expiry	
Date	
Immunisation	
Expiry	

Declaration
I declare that the answers to the above questions are true and complete to the best of my knowledge and belief. I also give consent for Healthier Business UK Ltd to make recommendations to my employer.

Signed _____ Print Name_____

Date _____