Healthscope (UK) Ltd
Occupational Health & Safety

INSERT COMPANY NAME AND/OR LOGO HERE

MEDICAL IN CONFIDENCE

EMPLOYMENT HEALTH QUESTIONNAIRE

Please complete this form and any supplementary pages as fully and as accurately as possible by placing a tick in the relevant box as required. When complete, please return this form in the envelope provided to our Occupational Health Advisor at **Healthscope (UK) Ltd** (address below) or email to admin@healthscopeuk.com, who will advise us on any adjustments that may be required. All information entered in this form is treated in the strictest confidence and will not be divulged to third parties without your express consent.

Title:	MALE / FEMALE	Surname:	Forenames	Date of Birth:

Home Address:

POST CODE:

Home Telephone Number:

Daytime Telephone Number:

Department Applied For:	Job Role Applied For:
Proposed Hours of Work per Week:	Proposed Start Date: **Temporary / Permanent** *(Delete as appropriate)*

Please give details of your previous employment:

Company:	**Job Title:**	**Date From:**	**Date To:**

Have you ever experienced or been exposed to any of the following in the course of your previous work or place of employment? (Tick boxes as appropriate)

	YES	**NO**		**YES**	**NO**
Chemicals?			Noise?		
Skin Irritants			Ionising Radiation?		
			Surgical glove problems		

Your weight in **KGS**		Your height in **CMS**	

Absence History

Detail below absence from work during the last 2 years because of medical reasons.		
Date:	**Duration in Days:**	**Reason:**

Have you ever been denied a job on health grounds? Yes/No

If yes please give details:

Have you ever been denied or had to give up a driving licence on health grounds? Yes/No

If yes please give details:

Will the proposed role involve any of the following (tick all relevant answers)

✓		**Additional detail**
	Working at heights	
	Regular travel (UK)	
	Regular travel (international)	
	Operating Machinery	
	Shift work	
	Night Work	
	Regular heavy lifting	
	Home working	
	Computer use	
	Driving	
	Noise exposure	
	Exposure to chemicals	
	Other	

Have you ever had any illness/impairment/disability which may have been caused or made worse by your work? Yes/No if yes please give details.

Have you been diagnosed as having dyslexia? Yes/No
Do you have any other health problems or concerns? Yes/No
Are you taking any prescribed medication? Yes/No
Have you suffered or been treated for any psychological ill health? Yes/No

If yes to any of above, please give details including any medication in box below.

Do you have any health condition that causes significant difficulty with the following activities? If **YES** please specify.

Ability to move about or stand?

Ability to use limb, hands or feet?

Ability to lift or carry?

Toilet use or access?

Memory or ability to learn or understand?

Awareness or reaction to danger?

I declare that the above particulars are true and complete to the best of my knowledge and belief and understand that failure to disclose medical information affecting my employment may lead to termination of my job.

Signed:_____ Date: _____

PRINT NAME:_____

In most cases this questionnaire is sufficient to make an assessment of your health. Where more information is required Occupational Health will need to write to your Doctor for a confidential report before a recommendation about employment can be made.
The declaration below gives permission for this.

DECLARATION
Please read and sign the consent below.

I have read the attached Notice of Statutory Rights under the Access to Medical Reports Act 1988. I consent to Healthscope (UK) Ltd seeking medical information from any doctor who has at any time attended me concerning anything which affects my physical or mental health. I agree that a copy of this consent form shall have the validity of the original.

I declare to the best of my knowledge that the answers to the questions above are complete and accurate and that I authorise the medical staff to perform a medical examination upon me, including any tests necessary to determine my state of health.

In order for us to approach your doctor, could you please provide us with the following information?

Title:		**Surname:**		**Forenames:**	
Date of Birth:					
Address:					
Post Code:		**Telephone Number:**			

About Your Family Doctor:

Full Name and Address of Your Family Doctor:			
Post Code:		**Telephone Number:**	

About Your Hospital Specialist:

Full Name and Address of your Hospital Specialist:			
Post Code:		**Telephone Number:**	
Your Hospital Number (if known):			

I CONSENT / DO NOT CONSENT* to my Doctor providing Healthscope (UK) Ltd with a medical report on me.

I WISH / DO NOT WISH * to see my Doctor's report before it is sent to Healthscope (UK) Ltd.

Delete as appropriate.

I understand Healthscope (UK) Ltd will retain the information on a confidential basis and that any advice given to management will be expressed in terms of my fitness for employment and/ or my fitness to carry out my duties both now and in the future. If I do not take up employment with the company, this form will be disposed of as confidential waste.

Signed:		Date:	