Pre-employment health questionnaire

Private and Confidential

Please complete and return this form as directed.
The health of each candidate is considered individually and no decision to reject a candidate on medical grounds will be made without a medical examination or medical advice being sought.
You should notify us immediately if you have any serious illness after completing this form and before you take up the appointment offered as a result of your application.
If you give any information that you know is false – or you withhold any information – your application may be rejected (or, if already appointed, you may be dismissed).

SECTION ONE – RECRUITMENT – TO BE COMPLETED BY THE EMPLOYER

Company: Department:

Name of person responsible for recruitment:

Name and contact telephone number of person to whom medical clearance should be returned:

Job title/position applied for:

Typical tasks associated with this job:

In which department will the employee be working?

Proposed date of joining company:

Please tick boxes regarding job hazards		**None**	☐
Heavy Physical work or manual handling	☐	Repetitive upper limb movements	☐
Extremes of temperature	☐	Noisy Environment	☐
Respiratory or skin hazards	☐	Vocational driving (HGV/LGV/PCV/Forklift)	☐
High mental demands	☐	Night work	☐

Other hazards – especially other chemical hazards – please specify

SECTION TWO – TO BE COMPLETED BY THE EMPLOYEE

Surname | Date of Birth

Forename | ☐ Male ☐ Female

Home address

Post code | Preferred Contact telephone number

SECTION THREE – MEDICAL HISTORY/DETAILS

Do you, or have you ever suffered from any of the following

(For questions 3.1 to 3.12 inclusively, indicate if you have ever suffered from any of the **following** conditions by underlining the appropriate condition **and providing details** in the comments box on the back page).

		Yes	**No**
3.1	tuberculosis, pleurisy, asthma, bronchitis, or any other lung, throat or ear complaint, including deafness.	☐	☐
3.2	any disorder of the heart, circulatory system, high blood pressure	☐	☐
3.3	persistent indigestion, gastric or duodenal ulcer, intestinal complaint or rupture	☐	☐
3.4	epilepsy or fits	☐	☐
3.5	any psychological or nervous complaint	☐	☐
3.6	diabetes, gout or any kidney or bladder complaint	☐	☐
3.7	any arthritis, slipped disc, rheumatism, back trouble or upper limb problem	☐	☐
3.8	dermatitis, other skin complaint or allergic condition	☐	☐
3.9	sleep apnoea, narcolepsy or cataplexy	☐	☐
3.10	frequent headaches or migraine	☐	☐
3.11	any eye complaint including blurred vision or eye discomfort	☐	☐
3.12	any other significant medical problem? (excluding coughs/cold/flu or any of the conditions listed above	☐	☐
3.13	Do you normally wear glasses or contact lenses	☐	☐

3.14 When did you last have any eyesight test? ……(month) ……(year)

If you answer 'Yes' to questions 3.15 to 3.20 please provide details in the comments box on the back page

		Yes	No
3.15	Do you have any difficulty in recognizing different colours?	☐	☐
3.16	Have you ever failed a medical examination of any kind?	☐	☐
3.17	Have you ever consulted, or been recommended to consult a medical specialist	☐	☐
3.18	Have you ever been in hospital as a patient? (**please provide details on page 4)**	☐	☐
3.19	Are you currently on any treatment being prescribed by a Doctor?	☐	☐

(If you answer 'Yes' to question 3.20, you may be sent a supplementary health questionnaire for completion so that the medical staff can assess appropriate and reasonable work adjustments for you)

3.20	With reference to the Disability Discrimination Act, do you have any physical or mental Impairment, which significantly affects your daily living?	☐	☐
3.21	Are you pregnant?	☐	☐

If yes, how far are you into the pregnancy? ……..(months)

SECTION FOUR – OCCUPATIONAL HISTORY/DETAILS

		Yes	No
4.1	Have you ever worked for the company before?	☐	☐

4.2 How many jobs have you had since you started work? …….

4.3 What industries have you worked in before applying for this job?

For example Machine operator for light engineering company *1985-1989*

_____ _____

_____ _____

_____ _____

For questions 4.4 to 4.8 inclusive – 'Have you ever worked…..

4.4	in a dusty environment?	☐	☐
4.5	in a noisy environment?	☐	☐
4.6	with chemicals?	☐	☐
4.7	with x-rays or other forms of radiation?	☐	☐
4.8	with vibrating tools?	☐	☐
4.9	had a repetitive strain injury or an upper limb problem?	☐	☐

4.10 had any problems related to alcohol? ☐ ☐

4.11 had any problems related to the use of illegal or prescribed drugs? ☐ ☐

4.12 had any disease or injury arising out of your work e.g. deafness, backache, dermatitis, asthma or vibration white finger? ☐ ☐

4.13 been advised for medical reasons not to do night work, shift work, or any other kind of work? ☐ ☐

4.14 undergone health surveillance due to hazards in your previous job? ☐ ☐

4.15 Are you in receipt of a disability pension? ☐ ☐

4.16 What is your height? ……feet/ins / metres **4.17** What is your weight? ……..stone/kgs

4.18 Do you smoke? ☐ No ☐ Yes If Yes….how many per day? (cigarettes/cigars/pipes) ……..

4.19 Do you drink alcohol? ☐ No ☐ Yes If Yes….what is your average …….units per week weekly intake?
(½ pint/glass wine/measure spirit = 1 unit)

4.20 SICKNESS ABSENCE
Within the past 12 months

How many days have you been unable to attend work/studies or undertake normal daily living tasks, through sickness? ……..

How many episodes of sickness absence have you had? ……..

Please use the text box to indicate the cause of any absence that you have had.

If you have answered "yes" to any questions on page 2 or 3 of this questionnaire, with the exception of questions 3.13, 3.14 & 3.21 or 4.1, 4.18 & 4.19, please give details in the space below, continuing on a separate sheet of paper if necessary, and include:

- The date that the problem occurred and whether the condition is still present
- Details of any medication used or treatment undertaken in connection with the condition, and
- Details of any other medical condition not referred to within this questionnaire.

Immunisation History
Please indicate whether you have received the following vaccines:

Diptheria Pertussis and Tetanus (DPT) Y/N
Measles Mumps and Rubella (MMR) Y/N
BCG (against Tuberculosis) Y/N
Hepatitis B Y/N
Varicella Y/N
If No to Varicella: Do you have a clear history of having had Chickenpox or Shingles? Y/N
Date of last Influenza Vaccination _____

GDPR Clause and Declaration – Pre-employment health questionnaire
Under the GDPR 2018 legislation, the information you supply about yourself in this form is known as your personal data and information about your health, medical history and any treatment you have received is called "sensitive personal data". The form including your "sensitive personal data" may be used by H&B Medical (OH) to assess whether you are fit for the post for which your application is being considered. Your consent is required before this processing can take place. Please see the declaration below.

SECTION FIVE – DECLARATION

PLEASE READ CAREFULLY. By signing this declaration you will be giving your consent to the processing of the information you have supplied. If you do not understand the content of this form, the content or effect of the declaration or you feel unable to give your consent, please contact the person responsible for recruitment mentioned on part 1 for further information.

I CONFIRM THAT I HAVE READ AND UNDERSTOOD THE DATA PROTECTION NOTICE ABOVE. I HEREBY AGREE AND CONSENT TO THE PROCESSING OF THE INFORMATION THAT I HAVE SUPPLIED ABOUT ME. I declare that all the foregoing statements are true and complete to the best of my knowledge and belief and I am not aware of any other medical condition not referred to elsewhere in this questionnaire. I understand that any misrepresentation will invalidate my application and if employed, could lead to my dismissal.
I understand that I may be required to undergo a medical examination by the company's appointed medical adviser for pre-employment purposes only.

Your signature:	**Date :**

SECTION SIX – DO NOT WRITE IN THIS SECTION OF THE QUESTIONAIRE
Initial review of PEHQ and further action required

☐ Obtain further information
☐ Obtain GP report
☐ Obtain consultant report
☐ Arrange IMA
☐ Issue DDA questionnaire (OHS 150)

Final Conclusion

☐ **Fit** for position
☐ **Unfit** for position

☐ Employee covered by DAA

☐ Fit for employment in a limited capacity ***or*** amendments to the working environment should be considered (see below).

Comments:

Clinician:	**Date:**