# 

CONFIDENTIAL EALING COUNCIL

CASE NO:

OCCUPATIONAL HEALTH UNIT

#### PRE-EMPLOYMENT MEDICAL QUESTIONNAIRE

The form can be posted to the Occupational Health Unit or sent via email from the applicant’s personal email address to [occupationalhealth@ealing.gov.uk](mailto:occupationalhealth@ealing.gov.uk)

|  |  |
| --- | --- |
| ***This section must be completed by the recruiting manager/school before giving the***  ***form to the applicant.*** | |
|  |  |
| Surname | First Names |
| Previous name | Female  Male |
| Address | Date of birth |
|  | Tel. no. (home) |
|  | Tel. no. (mobile) |
|  |  |
| Email address |  |
| Job title |  |
| Name of appointing officer/manager | Telephone no. |
| Employing department/school |  |
| Place of work       Full-time  Part-time  Contracted hours | |
|  | |
| Please tick any boxes below relevant to this post: | |
| 1. Food handling/preparation | |
| 1. Shift or night work | |
| 1. Work with powered machinery | |
| 1. Regular heavy lifting/handling/bending | |
| 1. Climb ladders or work at heights | |
| 1. Working with chemicals | |

Have you worked for this Authority before? Yes  No

If ‘YES’ please state post held

From       Until

###### FOR OHU USE ONLY

Results of medical assessment: Fit / Fit with recommendations / Unfit

Recommendations:

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Pre-employment medical questionnaire/Occupational Health/26.02.2020*

***This section is to be completed by the applicant***

Please answer **every** question. Failure to do so will delay the processing of your application. Please ensure you provide full details if you answer ‘yes’ to a question. Information about your health is **CONFIDENTIAL** and is only seen by the Occupational Health Staff.

|  |  |
| --- | --- |
| **Number of days absent from work due to illness or injury in the last year. Please give details:** | |
| Date: | Reason |
|  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| HAVE YOU EVER HAD? *PLEASE MARK YES OR NO* | **YES** | **NO** | **IF “YES” PLEASE GIVE DATES AND DETAILS** |
| Any chest/respiratory illness e.g Asthma or Tuberculosis (TB) |  |  |  |
| Raised blood pressure |  |  |  |
| Heart/Circulatory problems |  |  |  |
| Bowel problems |  |  |  |
| Gastric /stomach problems |  |  |  |
| Jaundice /liver problems |  |  |  |
| Hepatitis or HIV |  |  |  |
| Other blood disorders |  |  |  |
| Diabetes |  |  |  |
| Thyroid problems |  |  |  |
| Bladder problems |  |  |  |
| Kidney problems |  |  |  |
| Mobility difficulties |  |  |  |
| Back injury |  |  |  |
| Back pain |  |  |  |
| Difficulty in bending or lifting |  |  |  |
| Ruptures/hernia |  |  |  |
| Rheumatism |  |  |  |
| Joint pains |  |  |  |
| Arthritis |  |  |  |
| Mental illness |  |  |  |
| Admission to a psychiatric ward |  |  |  |
| Stress (Please advise cause and if work related) |  |  |  |
| Depression/Anxiety |  |  |  |
| Dyslexia/Dyspraxia/Dyscalculia |  |  |  |
| HAVE YOU EVER HAD? *PLEASE MARK YES OR NO* | **YES** | **NO** | **IF “YES” PLEASE GIVE DATES AND DETAILS** |
| Severe headaches/Migraine |  |  |  |
| Epilepsy/Fits |  |  |  |
| Neurological problems |  |  |  |
| Ear/ Nose/ Throat problems |  |  |  |
| Eye problems |  |  |  |
| Skin problems |  |  |  |
| Allergies |  |  |  |
| Are you receiving any medical treatment |  |  |  |
| Are you taking any medication; if yes, please list |  |  |  |
| Are you currently under a hospital specialist or awaiting an appointment; if yes, please specify condition |  |  |  |
| Any conditions not mentioned |  |  |  |
| Serious illness |  |  |  |
| Operation |  |  |  |
| Admission to hospital |  |  |  |
| Do you wear:-  Spectacles/ Contact Lenses  Hearing aid |  |  |  |
| Have you had a chest X-ray in the past 5 years?  If YES – give reason |  |  |  |
| Have you ever been exposed to a hazardous substance e.g. Asbestos |  |  |  |
| Have you ever had to leave or change any job due to ill health? |  |  |  |
| Do you have a pre-existing work related condition |  |  |  |
| Please state Height:       Weight: | | | |

### IMMUNISATION AGAINST INFECTIOUS DISEASES

|  |  |  |  |
| --- | --- | --- | --- |
| **Have you ever been vaccinated against**  **any of the following diseases?** | **YES** | **NO** | Please give date of last injection |
| Tuberculosis – BCG |  |  |  |
| Hepatitis B |  |  |  |
| Have you ever had a blood test to ascertain your immunity against Hepatitis B |  |  | Result |

Employment History: (Start with present or most recent job). Please attach separate sheet if necessary.

|  |  |  |
| --- | --- | --- |
| **Name of employer** | **Type of work (e.g. driver, secretary etc)** | **Dates employed** |
|  |  |  |

I declare that the information given in this document is true and correct to the best of my knowledge and I have omitted no relevant details. I understand that if any false statements are knowingly made this may result in my dismissal from the Council’s service.

**TO BE SIGNED BY THE CANDIDATE**

SIGNATURE       DATE

THE MEDICAL INFORMATION REQUESTED WITHIN THIS DOCUMENT WILL BE TREATED IN THE STRICTEST CONFIDENCE AND IS FOR THE USE OF THE OCCUPATIONAL HEALTH UNIT ONLY.

THE INFORMATION IS USED TO IDENTIFY ANY POTENTIAL ISSUES AND TO IDENTIFY WHERE FURTHER ASSESSENT OR REASONABLE ADJUSTMENT MAY BE REQUIRED OR WHERE THERE IS A HEALTH AND SAFETY CONCERN.

(THE INFORMATION WILL NOT BE USED TO DETERMMINE WHETHER OR NOT AN OFFER OF EMPLOYMENT WILL BE MADE.)