



Pre-Employment Medical Questionnaire

Personal Details:

| | |
|-----------------------|------------------|
| Male/Female: | Title: |
| Surname: | Forename(s): |
| Address | |
| Postcode: | Telephone No: |
| Date of Birth: | Maiden Name: |
| Post Applied for: | |
| Date of Commencement: | |
| Doctor's Name: | Doctor's Address |

This form asks questions about past and present health. It will be used to make an assessment of your health in relation to your employment.

I consent to this health questionnaire and interview.

Signed..... Date:.....

MEDICAL HISTORY:

| | Question | Yes/no | Details/Dates |
|----|---|--------|---------------|
| 1. | Have you ever attended hospital as an in/out patient? If so, please give reasons and dates. | | |
| 2. | Are you a Registered Disabled Person? | | |
| 3. | Have you had more than 2 weeks off work/school due to illness in the last 2 years? | | |
| 4. | Are you, at present, taking any tablets or medicine under medical supervision? | | |
| 5. | Have you had any defect of hearing or do you wear a hearing aid? | | |
| 6. | Have you any defect of sight or do you wear spectacles or contact lenses? | | |

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|-----|--|--|--|
| 7. | Are you colour blind? | | |
| 8. | Have you had a chest x-ray in the last 12 months? | | |
| 9. | Anaemia blood disease or bleeding disorder? | | |
| 10. | Diabetes, thyroid or gland disorder? | | |
| 11. | Drug or alcohol addiction? | | |
| 12. | Hernia, rupture or varicose veins? | | |
| 13. | Migraine or frequent headaches? | | |
| 14. | Jaundice or hepatitis? | | |
| 15. | Typhoid, enteric fever, food poisoning or prolonged or severe diarrhoea? | | |
| 16. | Recurrent tonsillitis, sinusitis or hay fever? | | |
| 17. | Discharging ears, perforated eardrums? | | |
| 18. | Frequent/ recurrent infection of the eyes (styes /conjunctivitis)? | | |
| 19. | Allergies? | | |
| 20. | Skin sensitivity to any specific materials? | | |
| 21. | Backache, back injury or slipped disc? | | |
| 22. | Prolonged pain, arthritis or injury to the neck? | | |
| 23. | Severe injury or disability of upper or lower limbs? | | |
| 24. | Fits, epilepsy, fainting attacks, blackouts or giddiness? | | |
| 25. | Nervous breakdown, mental illness, depression or any nerve trouble? | | |
| 26. | Heart disease, angina, raised blood pressure? | | |
| 27. | Breathlessness, palpitations, swelling of the ankles? | | |
| 28. | Disease of the nervous system (Parkinson's, multiple sclerosis, etc)? | | |
| 29. | Asthma, bronchitis, pneumonia, TB or other chest illness? | | |
| 30. | Rheumatism, rheumatic fever, arthritis or other joint problems? | | |
| 31. | Cystitis, bladder or kidney disorder? | | |
| 32. | Indigestion, stomach or bowel disorder? | | |
| 33. | Any illness or infection, operations or serious injury not mentioned already (other than childhood illnesses)? | | |