OCCUPATIONAL HEALTH QUESTIONNAIRE FOR THE LEE TUNNEL CONTRACT

Confidential Health Declaration

Candidates should note that failure to disclose relevant health details could prejudice your future employment. You are asked to complete this Questionnaire carefully so that an assessment can be made of your health and well being in relation to your proposed employment, and to ensure that there are no problems which could affect your health or the Programme's safety. The Questionnaire will be part of your basic health record and the data provided will be stored for the lifespan of the Programme. Its contents will be treated in the strictest confidence and will not be discussed or seen outside MVB Occupational Health Department unless you give your written consent and will remain completely confidential.

PLEASE COMPLETE ALL SECTIONS OF THE FORM IN CAPITAL LETTERS AND AS FULLY AS POSSIBLE.

1. PERSONAL DETAILS

Name:	Date of Birth:
Address:	
Family Doctor's Name and Address:	

2. EMPLOYMENT ABSENCE HISTORY

Please give details of any sickness absence from work in the last 2 years.

DATE	REASON FOR ABSENCE / CAUSE	DURATION

3. MEDICAL HISTORY

Please tick the relevant box.

Question Number	**Have you ever suffered from?:**	**YES**	**NO**
1	Eye Disease or visual problems (including colour blindness) not corrected by glasses		
2	Disabling headaches or migraine		
3	Ear disease or hearing problems		
4	Stomach or bowel problems (e.g. diarrhoea or indigestion)		
5	Jaundice or Hepatitis or other liver problems		
6	Hernia (rupture)		
7	Heart disease, high/low blood pressure or strokes		
8	Asthma, Tuberculosis or other chest disease		
9	Kidney disease		
10	Epilepsy, fainting, dizziness or loss of consciousness		
11	Diabetes		
12	Any skin problems (e.g. eczema, dermatitis) or recurrent infections		
13	Allergies (to drugs or any other substance) or hayfever		
14	Problems with your feet, knees or hips		
15	Problems with your hands, wrists, elbows or shoulders		
16	Rheumatism or arthritis		
17	Any form of back trouble or neck trouble (e.g. sciatica, back pain, disc trouble, spondylitis, or whiplash injury)		
18	Mental or nervous illness such as depression or anxiety		
19	Rapid weight gain or loss or eating disorders		
20	Any form of cancer or abdominal growths		

Question Number	Have you ever suffered from?:	YES	NO
21	Any form of work related injury or illness:		
	Hand Arm Vibration (VWF)		
	Noise induced hearing loss		
	Dermatitis/Skin problems		
	Occupational Asthma		
22	Are you attending hospital or receiving any medical treatment/therapy at present?		
23	Have you ever had any operation, serious illness or injuries?		
24	Do you take medicines, tablets or use ointments regularly at present?		
25	Have you ever had any alcohol or drug problems		
26	Have you any other health problems not already mentioned that may affect your work?		
27	Have you ever left previous employment for health reasons (e.g. medical retirement)?		
28	Are you receiving compensation or claiming for a work related illness?		

What is your Height? _____ *What is your Weight?* _____

If you have answered 'Yes' to any of the questions on Medical History, please give details in the box below, or complete on separate page with name, Date of Birth on Sheet

4. PERSONAL HABITS

Do you smoke? YES ☐ NO ☐

Have you ever smoked? YES ☐ NO ☐

How many cigarettes per day (or Ozs of tobacco)? ☐

How old were you when you stopped smoking? ☐

When did you stop smoking? ☐

Do you drink alcohol? YES ☐ NO ☐

If YES, how many units per week? ☐

(1 unit = half pint of beer or one pub measure of spirits or one glass of wine)

Do you have a regular dental check? YES ☐ NO ☐

How often? ☐

Do you wear glasses? YES ☐ NO ☐

Do you wear contact lenses? YES ☐ NO ☐

Do you take any exercise?

If yes, please give details. ☐

5. IMMUNISATION/INFECTIOUS DISEASES

Have you ever had any adverse reactions to Any medicine or foods? YES ☐ NO ☐

Have you ever been immunised against any of the following?	**YES**	**NO**	**DATE**	**ANTIBODY RESULT**
Poliomyelitis				
German Measles (Rubella)				
Tetanus				
Hepatitis B **				
Hepatitis A				
Tuberculosis				
Chicken Pox				

**** If you are involved in Exposure Prone Procedures, a Valid Certificate of Immunity is required before you will be passed fit for employment**

6. DECLARATION

Please read this carefully before signing.

I confirm that the details and information given in this form are complete and correct and that if I make a false statement this could result in my employment being terminated immediately and without notice.

I understand that my answers to the questionnaire and any reports obtained from my Medical Advisers will be used by the Occupational Health & Safety Advisory Service to advise on my fitness of the proposed employment.

Signature: ……

Date: ……

The information provided in this Questionnaire will be checked by the Occupational Health Advisor. Information relating to your health will only be given to Management if it is likely to affect your, or other's, health and/or safety at work, in which case only relevant information will be provided in suitable form to preserve confidentiality.

Occupational Health Advisor to complete:-

		OH Notes
F1	Fit without restrictions	
F2	Fit with restriction	
U1	Temporarily Unfit Reason and action deemed appropriate	
U2	Permanently Unfit State reason and action deemed appropriate	