**A Healthcare team that puts your needs first**

**Addilyn Care Services**

Pre- Employment Health Assessment

The information gathered from this questionnaire will be confidential to ADDILYN CARE SERIVCES. Access to this information will not be given without your written permission.

The aim of this questionnaire is to assess if you have any health problems that could affect your ability to undertake the duties of the post which you applied for. Here at Addilyn Care Services we like to promote health for all our staff and agency worker.

**Please complete the following form and bring back to Addilyn Care Services.**

**SECTION A: PERSONAL DETAILS**

|  |  |  |  |
| --- | --- | --- | --- |
| Title : |  | Surname: |  |
| **Forename:** |  |  |  |
| **Date of Birth:**  |  | **Male / Female*****Please circle the appropriate answer*** |  |
| **Address:****Post Code:** |  |  |  |
| **Mobile Number:**  |  |  |  |
| **Telephone Number:**  |  |  |  |
| **GP’s Name:**  |  |  |  |
| **GP’s Address:**  |  |  |  |

|  |
| --- |
| Job Title:  |
| Current Job Position: |
| Have you worked in the NHS in the last 12 months: *please circle the appropriate answer* Yes / No |

**SECTION B – MEDICAL HISTORY**

|  |  |  |  |
| --- | --- | --- | --- |
| Have you ever had or do you have now, any of the following? Please tick the appropriate box | Yes  | No | Don’t Know  |
| **Impairment which may affect your ability to work safely?**  |  |  |  |
| **Eyesight problems not corrected with glasses/contact lenses?** |  |  |  |
| **Hearing problems not corrected with a hearing aid?** |  |  |  |
| **Difficulty in standing, bending, lifting or other movements?** |  |  |  |
| **Any kind of back problem?** |  |  |  |
| **Have your ever suffered discomfort when using a computer keyboard?**  |  |  |  |
| **Any mental illness or psychological problems e.g. depression, nervous breakdowns, eating disorder, substance misuse or other?**  |  |  |  |
| **A drug or alcohol problem?** |  |  |  |
| **Fits, blackouts or epilepsy?**  |  |  |  |
| **Any Allergies?****If yes please state what your allergies are?** |  |  |  |
| **Asthma, bronchitis or chest problems?** |  |  |  |
| **Treatment for TB?** |  |  |  |
| **In the last 12 months have you had a cough for more than 3 weeks, ever coughed up blood or had any unexplained loss of weight or fever?** |  |  |  |
| **Diabetes, thyroid or gland problems?** |  |  |  |
| **Any illness which may have caused or been made worse by your work?** |  |  |  |
| **Episodes of chest pains or breathlessness?** |  |  |  |
| **Suffer from heart disease or high blood pressure?** |  |  |  |
| **Are you at present taking or receiving any form of medication?** |  |  |  |
| **Any operations?** |  |  |  |
| **Been retired on the grounds of ill health?** |  |  |  |
| **Are you waiting for or receiving treatment for any medical or mental health?** |  |  |  |
| **Have you ever suffered with stress associated with work?** |  |  |  |
| **Have you’re ever suffered with stress associated with work?** |  |  |  |
| **Have you ever suffered from Stomach, Bowel or intestinal disorders?** |  |  |  |
| **Have you ever been screened for MRSA?** |  |  |  |
| **Are you pregnant?** |  |  |  |
| **Are you currently takin any drugs or medicines prescribes by a doctor or purchased from a pharmacy? If so please give the name of the drug/medication and daily dosage** |  |  |  |
| **Is there any additional relevant information regarding your health not covered in the above question?****If yes please what other medical conditions we should be aware of?** |  |  |  |

**SECTION C - FOOD HANDLERS**

|  |  |  |
| --- | --- | --- |
| Are you currently suffering from or have you suffered from any of the illnesses listed below in the past 3 months? | Yes | No |
| **Diarrhoea**  |  |  |
| **Blood Poisoning**  |  |  |
| **Skin Trouble**  |  |  |
| **Ear or Eye Infection**  |  |  |
| **Sore Throat**  |  |  |
| **Sinusitis**  |  |  |
| **Lung Disease (e.g. Bronchitis TB)**  |  |  |
| **Persistent Cough**  |  |  |
| **Vomiting (as a result of known or suspected food poisoning?** |  |  |

**SECTION D -SICKNESS ABSENCE**

|  |
| --- |
| **How many days have you lost from work during the past 2 years?****What was this due to?** |
|  |

**SECTION E - IMMUNISATIONS**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Yes  | No  | Don’t Know | Dates  | Results  |
| **BCG (proof required by health professional)** |  |  |  |  |  |
| **Tetanus** |  |  |  |  |  |
| **Poliomyelitis**  |  |  |  |  |  |
| **Hepatitis A** |  |  |  |  |  |
| **Hepatitis B: 1,2 & 3**  |  |  |  |  |  |
| **Hepatitis B booster** |  |  |  |  |  |
| **Hepatitis antibody screen (copy of blood test result required)** |  |  |  |  |  |
| **Rubella**  |  |  |  |  |  |
| **MMR 1st Vaccination**  |  |  |  |  |  |
| **MMR 2nd Vaccination**  |  |  |  |  |  |
| **Have you ever had Chickenpox or Shingles?**  |  |  |  |  |  |
| **Chest X Ray (clear?)** |  |  |  |  |  |

**Any other Immunisation or Vaccination Information?**

**SECTION F – EXPOSURE PRONE PROCEDURES**

**Health care workers who perform Exposure Prone Procedures have a legal duty to inform their employer if they suspect or know they are carriers of HIV, Hepatitis B or Hepatitis C. Health care workers who perform Exposure Prone Procedures have a legal duty to inform their employer if they suspect or know they are carriers of HIV, Hepatitis B or Hepatitis C.**

**If you are expected to carry out EPP’s fitness for employment will not be given until Occupational Health Advisor has seen documentary evidence of Hepatitis B, Hepatitis C and HIV status.**

|  |  |  |
| --- | --- | --- |
| Have your tested positive for any of the following? | Yes  | No  |
| **Hepatitis B** |  |  |
| **Hepatitis C** |  |  |
| **HIV** |  |  |

**SECTION G – NIGHT WORKER**

**The following section is to be completed only by those members of staff who regularly undertake night duty.**

|  |  |  |
| --- | --- | --- |
|  | Yes  | No |
| **Have you worked nights before?**  |  |  |
| **If yes: Did you suffer any health problems directly related to night work?**  |  |  |
| **If Yes: Give Details**  |  |  |
| **Heart or Circulatory Disorders**  |  |  |
| **Stomach, Bowel or Intestinal Disorders**  |  |  |
| **Do you have any medical condition that may affect your ability to work at night?** |  |  |

**SECTION H –** If you need any extra space for the above questions, use the extra space provided below.

|  |  |
| --- | --- |
| **Question Number**  | **Details**  |
|  |  |
|  |  |
|  |  |

**SECTION I – DECLARATION**

**I declare the answers that I have provided in this form is correct to the best of my knowledge. I understand that if I should be found to make false statements about my medical history the Addilyn care Services will terminate my contract without notice.**

**Signature: ……………………………………………………………………………..**

**Date: …………………………………………………………………………..**

**Print Name: ………………………………………………………………..**

**FOR OFFICIAL USE ONLY**

**Result of Health Questionnaire**

|  |  |
| --- | --- |
| Name of Candidate  |  |
| **Position**  |  |
| **Branch**  |  |
| **Date of review of health questionnaire**  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Outcome of Deferral/Referral  | *Fit*  | *Fit with Restrictions* | *Unfit*  | *Fit for EPP*  |
|  |  |  |  |  |

|  |  |  |
| --- | --- | --- |
| Immunisations Required  | Tick | Restrictions  |
| **Mantoux Test**  |  |  |
| **BCG Scar** |  |  |
| **Hepatitis B 1,2 & 3** |  |  |
| **Hepatitis B booster**  |  |  |
| **Hepatitis B Antibody Screen**  |  |  |
| **Hepatitis A 1 & 2** |  |  |
| **Varicella**  |  |  |
| **Rubella** |  |  |
| **No Immunisations required**  |  |  |

**Signature of Occupational Health: …………………………………………………..**

**Date: ……………………………………………………………………..**

**Date personnel notified in writing: ……………………………………………..**

**Date personnel notified by telephone: ……………………………………….**