#### ANNUAL MEDICAL QUESTIONNAIRE

#### **PART 1: PERSONAL DETAILS**

#### **Please complete all sections as indicated.**

#### **Please use Black ink when completing this form.**

**Upon completion, please return to head office.**

**PERSONAL DETAILS**

| **To be completed by ALL STAFF (Section A)** | | | |
| --- | --- | --- | --- |
| Address: | Telephone numbers:  Home:  Work: | | |
| Postcode: |  | | |
| Date of Birth (dd/mm/yy): | Age (Years): | | Sex: M ☐ F ☐ |
| **Personal Mobile Phone and Home Email information** | | | |
| Do you consent to being contacted by email? Yes ☐ No ☐  If Yes, please provide your home email address | | Home email address: | |
| Do you consent to being contacted on your mobile? Yes ☐ No ☐  If Yes, please provide your mobile phone number | | Mobile phone number: | |

**PART 2: To be completed by All Staff**

| **Please answer all of the following questions by ticking the box** | | **Yes** | **No** |
| --- | --- | --- | --- |
| 1 | Are you on a hospital waiting list for investigation or treatment? | ☐ | ☐ |
| 2 | Are you regularly attending a hospital, community clinic or seeing a doctor? | ☐ | ☐ |
|  | **Are you suffering from or have you ever suffered from?** | **Yes** | **No** |
| 3 | Any conditions relating to your heart or circulation? | ☐ | ☐ |
| 4 | Any respiratory problems? (e.g. Asthma) | ☐ | ☐ |
| 5 | Any psychological problems? (e.g. nervous breakdown/depression) | ☐ | ☐ |
| 6 | Any eyesight condition that cannot be corrected by wearing spectacles or contact lenses? | ☐ | ☐ |
| 7 | Any ongoing hearing problems or ear disorders? (e.g. Tinnitus) | ☐ | ☐ |
| 8 | Any ongoing bone, muscle or joint problems? (e.g. Recurrent back pain/Arthritis) | ☐ | ☐ |
| 9 | Any skin diseases or conditions that require medical treatment? | ☐ | ☐ |
| 10 | Any gastro-intestinal or abdominal problems? (e.g. Hernia/Gall Stones) | ☐ | ☐ |
| 11 | Any blood or metabolic disorders? (e.g. Anemia/Diabetes) | ☐ | ☐ |
| 12 | Any neurological conditions? (e.g. severe headaches/vertigo/epilepsy) | ☐ | ☐ |
| 13 | Any long term or debilitating illness? (e.g. Multiple Sclerosis) | ☐ | ☐ |

**PART 3: To be completed by All Staff**

**DISABILITY DISCRIMINATION ACT 1995**

It is unlawful to discriminate against disabled people in connection with employment. A person is considered disabled if he or she has a physical or mental impairment which has a substantial and long term adverse affect on their ability to carry out normal day-to-day activities. In order to comply with the Disability Discrimination Act, we need to know if you are disabled.

It may be helpful for us to understand the nature of your disability in order to consider what adjustments may need to be made to the workplace to help you perform your job effectively and to comply with Health and Safety.

| **Disability** | **Yes** | **No** |
| --- | --- | --- |
| Do you have any kind of chronic health condition or disablement?  *(If yes, please answer both questions below)* | ☐ | ☐ |
| Do you believe that this condition or disablement might bring you within provisions of the Disability Discrimination Act 1995? | ☐ | ☐ |
| Do you consent to the nature of your disability (as determined by the Occupational Health department) being made available to your prospective employer to assist them in ensuring that the job is properly fitted to your needs?  If Yes, please describe the nature of your disability below: | ☐ | ☐ |
|  | | |

**PART 4: Declaration of Fitness**

**I** certify that I have answered all questions in Parts 1 to 3 of this form to the best of my ability and knowledge, and am able to answer **NO** to **ALL** questions in part 3. I have no reason to believe that my health will interfere with my ability to undertake the duties of the post for which I am Employed, or affect my ability to give good attendance. I understand that withholding information or knowingly giving incorrect information, about my health on this form may result in disciplinary action or dismissal.

| Signed: |  |  | Date (dd/mm/yy): |  |
| --- | --- | --- | --- | --- |

| Print Name: |  |
| --- | --- |

Line Manager: ……………………………. Name……………………………. Date ………………….

Reviewed by …………………………………… Date …………………………