

## Pre-Employment Health Assessment

*All sections to be completed by applicant using BLACK ink and block capitals*

### Part A:

The following information is required for our records and for the monitoring requirements of the employing organisation. Information from this questionnaire will be held in secure conditions within the Occupational Health Service, which may include computer storage in compliance with the Data Protection Act.

Surname: ..... Mr / Mrs / Miss / Ms / Dr / Prof:.....

Previous Surname(s) / Maiden Name: .....

Forename: .....

Address: .....

.....

..... Postcode: .....

Date of birth: ..... Ethnic Origin: .....

Daytime tel. no.: ..... Evening tel. no.: .....

Personal email address (*not work*): ..... *optional*

National Insurance Number – *important to complete*:.....

Post applied for: ..... Contract Hours: ..... per week

Ward / Department: ..... Hospital / Base Unit:.....

### Part B: Hepatitis B

If your post involves “exposure prone procedures” or contact with blood / bodily fluid / body tissue (see enclosed risk assessment form) you should attach documentary evidence of your Hepatitis B status to this questionnaire.

Individuals undertaking “exposure prone procedures” and registered nurses working for NHS Professionals will not receive health clearance until the Occupational Health Service receives acceptable documentary evidence of immunity or freedom from infection from an accredited United Kingdom laboratory.

**For Occupational Health Service Use Only:**

**Fitness Grade:**

**Date:**

**Signature:**

### HEALTH DECLARATION

In accordance with medical confidentiality your answers to the following questions will not be revealed to anyone without your permission. You may be contacted by telephone / letter or asked to attend for a medical assessment to clarify your fitness for work.

**Part C: To be completed by applicant using BLACK ink and block capitals**

	If you answer <b>Yes</b> to a question, you must give further details in the area provided. Lack of information may delay any appointment decisions.	Yes	No
1	<b>Have you previously been employed by any of the NHS Trusts in the Bristol and Weston areas?</b> <i>If yes, please state which .....</i>		
2	<b>Have you ever retired on health grounds?</b> <i>If so, please give details</i>		
3	<b>Have you lost time from work / school due to illness in the last 12 months?</b> <i>If yes, how many days, and state the reasons below</i>		
4	<b>Are you having medical treatment of any sort at the moment?</b> <i>For example, regular routine medication</i>		
5	<b>Have you seen your doctor or any other health professional in the last 12 months?</b> <i>Other than for routine visits or minor problems such as colds and flu</i>		
6	<b>Have you been to hospital for any test or treatment in the last 3 years, other than for minor problems OR are you waiting for any treatment or tests?</b> <i>For example, x-rays, scans, blood tests, ECG, operations, appointment etc.</i>		
7	<b>During the last 6 months have you had a cough lasting more than 2 weeks or any unexplained weight loss?</b>		
8	<b>Have you ever tested positive to a blood borne virus such as Hepatitis B / C or HIV?</b>		

	<b>Have you ever been treated for or suffered from the following?</b>	<b>YES</b>	<b>NO</b>
<b>9</b>	<b>Mental Illness</b> , including anxiety, depression, eating disorders, alcohol abuse, drug abuse, emotional or psychological problems?		
<b>10</b>	<b>Back or neck pain</b> , lasting more than 2 weeks or on more than 2 occasions?		
<b>11</b>	<b>Musculo-skeletal problems</b> , such as arthritis, pains in the arms, hands, wrists, legs or feet?		
<b>12</b>	<b>Skin problems</b> , including eczema, dermatitis or allergies?		
<b>13</b>	<b>Respiratory disorders</b> , such as asthma, bronchitis, TB or respiratory allergen?		
<b>14</b>	<b>Epilepsy</b> , fits or episodes of unconsciousness?		
<b>15</b>	<b>Diabetes?</b> Please give details...		
	<b>Do you suffer from, or have ever had any of the following?</b>	<b>YES</b>	<b>NO</b>
<b>16</b>	<b>Eye disease</b> ( <i>those not corrected by wearing lenses</i> ), including colour blindness?		
<b>17</b>	<b>Hearing or balance disorders?</b>		
<b>18</b>	<b>Work related allergies?</b> <i>For example, latex, metals, medicines, chemicals, foods</i>		
<b>19</b>	<b>Ill effects from working night shifts?</b>		
<b>20</b>	<b>Chronic fatigue syndrome?</b>		

**Part D: Supplementary information - to be completed by applicant**

**Disability Discrimination Act 1995**

**What is a disability?**

A disability is defined as a physical or mental impairment, which has a substantial and long-term adverse effect on a person's ability to carry out normal day-to-day activities. Where the impairment stops having a substantial adverse effect on a person's ability to carry out day to day activities, it will be treated as continuing to have that effect if that effect is likely to recur. A long-term impairment is one, which has lasted, or can reasonably be expected to last, at least 12 months.

**Do you consider that you have a disability as defined by the Disability Discrimination Act 1995?**

See definition above and tick the relevant box      YES       NO

If, YES, please give details:

**Part E: Pregnancy - to be completed by applicant if applicable**

It is recognised that pregnancy may increase the risk, to some individuals, from certain hazards in the workplace. Occupational Health can provide advice about this on a confidential basis.

If you would like to discuss this further, please tick the relevant box.      YES       NO

**Part F: Consent to access previous records - to be completed by applicant**

Do you consent, if applicable, to Avon Partnership OH Services accessing any previous occupational health records held in connection with NHS employment?

YES       NO       Signed: .....

**Part G:**

**Have you checked that you have completed all the sections in this questionnaire?  
Failure to do so may result in delay in the processing of your application**

**Please read carefully before signing below**

- I declare that the answers to the above are correct to the best of my knowledge.
- I understand that should I knowingly make a false statement regarding my medical history, either in my answers above or in statements to the Occupational Health Nurse or Doctor, or wilfully conceal any material fact, that if employed, I may be liable to disciplinary action which could lead to dismissal.

Signed: .....      Date: .....