WeLead Healthcare Service
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NEW EMPLOYEE CLINICAL MEDICAL QUESTIONNAIRE

Please return completed questionnaire to the above e-mail address

Part A – Personal Details - to be completed by the Applicant

Surname (Dr/Mr/Mrs/Ms/Miss) _____

Forename(s) _____ Previous Surname _____

Date of Birth _____ Male/Female _____

Address _____

_____

Post Code _____ Home Telephone Number _____Mobile _____

E-mail Address _____

Name and Address of General Practitioner _____

_____

National Health Service Number:										

Part B – Post Details

Post Applied for: _____Job Title: _____

Ward/Department: _____

Proposed Start Date: _____ Permanent/Temporary: _____

Part C – Occupational History

Is this your first NHS Post? (Please circle) Yes No

Have you lived outside the UK in the previous 12 months? (Please circle) Yes No

If yes, where and dates: _____

Part D – Medical History

If you have ever suffered from any of the following, please enter **Y** (Yes) or **N** (No) in the appropriate box

Chest pains or Angina		Asthma		Bronchitis		Anorexia/Bulimia	
Heart disease		Varicose Veins		Breathlessness		Rheumatic Fever	
Stomach Problems		Cancer		Ear Trouble		Depression/Anxiety	
Fainting Attacks		Fits/Blackouts		Dizziness		Jaundice	
Mental Illness		High Blood Pressure		Migraine		Diabetes	
Skin Complaints / Psoriasis / Eczema		Rheumatism / Arthritis		Back Pain/Back Injury		Hay Fever / Allergy	
Bowel Disorders		Kidney /Bladder Problems		Aids / HIV / Hepatitis B/C		Hernia	
Mental Health Problems		Hearing Problems		Anaphylaxis		Liver problems	
Eye problems		Repetitive Strain					

If the answer to any of these questions is 'Yes' please give details below including details of any illness, injury or health problems not listed above. Please use a separate sheet of paper if necessary.

	Yes	No	Details
Do you suffer from symptoms of general allergy or skin problems caused by wearing gloves at work?			
Have you or your family ever suffered from Tuberculosis?			
Have you any recent history of unexplained weight loss, fever, night sweats, persistent cough or coughing up blood?			
Are you receiving medical treatment from your GP or hospital?			
Are you taking any tablets, medicine or injections?			
Have you ever had Chickenpox?			
Have you ever had Measles?			
Have you ever had German Measles (Rubella)?			

Do you smoke (please circle) Yes No

If so, how many per day _____

Do you drink alcohol Yes No

If so, how much per week on average _____

Are you pregnant (please circle) Yes No, If yes how many months_____

What is your Height _____?

What is your Weight _____?

Part E – Vaccination History

Please give dates of vaccinations and blood tests

IMMUNISATION	YES	NO	DATE GIVEN	GIVEN AT GP / OCCUPATIONAL HEALTH
Tetanus				
Rubella (German measles)				
Measles				
Varicella (Chicken Pox)				
Polio				

	BCG	Date Given	Scar Visible	Site
A BCG vaccine is an injection usually given at the age of 13 in the upper arm. It leaves a characteristic scar.	Yes/No		Yes/No	

TB SCREENING	Yes	No	Date Given	Date Read	Result
HEAF TEST/MANTOUX					

HEPATITIS B Vaccine	Yes	No	Date Given	Given at GP / OCC Health
1				
2				
3				

Blood Tests	Date Taken	Results
Hepatitis B Antibodies		
HIV/AIDS Screening		
Hepatitis B Screening		
Hepatitis C Screening		
Rubella Screening		
Varicella Screening		
Measles Screening		

IMPORTANT	Yes	No
Will You Have Patient Contact		
Will This Post Involve Carrying Out Exposure Prone Procedures		

Employees who have patient contact will be required to provide documented evidence of measles screening.

Employees who perform Exposure Prone Procedures will be required to provide documented evidence of Hepatitis B/C and HIV immunity or status when returning this questionnaire. Failure to provide this information could delay your employment.

Part F – Work History

Please enter total sickness absence days in previous two years _____

Number of occasion's _____

Have you ever left a job or been excused work duties due to ill health? (Please circle) Yes No

Are you or have you been in receipt of a disability pension or other disability benefit? Yes No

Do you consider yourself to be disabled? Yes No

If you are pregnant you are advised to inform the Occupational Health Department, in order that you may be advised regarding physical, chemical or biological hazards in the workplace.

Are you pregnant? (Please circle) Yes or No

Part G – Declaration

The purpose of a pre-employment health assessment is to ensure as far as possible that you are fit for the post you have applied for in order to protect your own and others health and safety. Therefore, it is important to complete all sections. Failure to disclose information or by giving false information may result in withdrawal of the offer of employment or disciplinary procedure, which may lead to dismissal.

You may be required to attend the Occupational Health department for a medical assessment with a doctor or nurse.

Please sign the following declaration: -

I declare that the information I have given is to the best of my knowledge, true and complete.

Signature _____ Date _____

In order to assess your fitness to work we may need to obtain a report from your General Practitioner regarding information on this health questionnaire.

If this is necessary, we will contact you before proceeding.

In such cases you have certain rights under the Access to Medical Reports Act 1988.

I give consent to the Occupational Health Doctor obtaining information from my General Practitioner and authorize the giving of such information for the purpose of this pre-employment assessment only.

Signature: _____ Date: _____

Print Name_____