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Medical Questionnaire

Employee Name:	
Manager Name:	
Department:	
Date:	

Current Health and Welfare:	
Are you currently taking or have been prescribed medication (excluding contraceptives)?	Yes / No
If Yes, please give further details:	
Are you currently receiving or awaiting treatment for any physical or mental condition?	Yes / No
If Yes, please give further details:	
Do you suffer from any injury, illness, medical condition or allergy that might affect your ability to perform your duties?	Yes / No
If Yes, please give further details:	
Do you consider yourself to have a disability?	Yes / No
If Yes, please give further details:	

Medical History

Should you answer yes to any of the questions, please provide details on a separate sheet:

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Have you ever been refused a job on health grounds?	**Yes / No**
Have you ever been advised against carrying out any specific work task on health grounds?	**Yes / No**
Have you ever had to give up work for medical reasons?	**Yes / No**
Have you has any health problems which have been caused by shift working (particularly working night shifts)?	**Yes / No**
Have you had an illness or accident which has caused you to be admitted to hospital?	**Yes / No**
Have you been absent from work for more than 10 days in the past 12 months for any medical reason?	**Yes / No**
Have you consulted your own doctor or any other health practitioner in the past 3 months?	**Yes / No**

Do you now, or have you ever suffered from:

Eye disease or visual problems including impaired colour vision?	**Yes / No**	Any skin problems or recurrent infections?	**Yes / No**
Dyslexia or literacy problems?	**Yes / No**	Allergies or hay fever?	**Yes / No**
Disabling headaches or migraine?	**Yes / No**	Any problems with lifting or bending?	**Yes / No**
Ear disease or hearing problems?	**Yes / No**	Any problems with prolonged or repeated crouching or kneeling?	**Yes / No**
Stomach or bowel problems?	**Yes / No**	Any problems raising your arms above should height?	**Yes / No**
Jaundice, Hepatitis or other liver problems?	**Yes / No**	Any problems with back ache or neck ache?	**Yes / No**
Hernia?	**Yes / No**	Any problems with your hips and/or knees?	**Yes / No**
Heart disease, high/low blood pressure or strokes?	**Yes / No**	Any problems with your shoulders or elbows?	**Yes / No**
Asthma, TB or other chest problems?	**Yes / No**	Any problems with any other joints or muscles?	**Yes / No**
Kidney disease or bladder complaint?	**Yes / No**	Any bone fracture or break, joint dislocation or surgery to muscles?	**Yes / No**
Epilepsy, fainting, dizziness or loss of consciousness?	**Yes / No**	Anxiety, depression, stress, schizophrenia or other mental health disorder?	**Yes / No**
Any nervous system disorder?	**Yes / No**	Any alcohol, drug or other substance dependency?	**Yes / No**
Any form of brain tumour, brain or head surgery?	**Yes / No**	Any form of cancer or abdominal growth?	**Yes / No**
Any serious head injury?	**Yes / No**	Any medical conditions, other than those listed, which may affect you at work?	**Yes / No**
Sleep apnoea or narcolepsy?	**Yes / No**	Diabetes?	**Yes / No**

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If you answered yes to any of the above questions, please provide additional details:

Occupational Hazards – have you been exposed to any of the following hazards in any previous employment?			
Noise	**Yes / No**	Isocyanate Paints	**Yes / No**
Vibration	**Yes / No**	Other Chemicals	**Yes / No**
Mineral Oil	**Yes / No**	Radiation	**Yes / No**
Asbestos	**Yes / No**	Physically Demanding Work	**Yes / No**

If you answered yes to any of the above questions, please provide additional details:

Outcome of review: (tick as appropriate)	No action required. For information only	
	Further advice/information sought (please provide details)	

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	Immediate action required (please provide details)	
Additional Information:		

DECLARATION

I declare that the above information is an accurate and true summary surrounding my current medical condition.

Employee Signature:		Date:	
Manager Signature:		Date:	