



Pre Employment Questionnaire

Personal Information

Title: Mr, Mrs, Ms, Miss	Surname	1 st Name	DOB
Home Tel:	Work Tel:	Mobile:	
Home Address:		GP Address	

Screening History

Name of trust or hospital that gave you most recent screening	
Date of most recent screening	
Were the results in anyway abnormal?	

If the results were abnormal please provide details in the space below

Details:

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Basis Health History

If your answer to any of these questions is **YES**, or if you are currently taking any medication please provide details in the space below.

	YES	NO
Is there any aspect of your health which may restrict your ability to work		
Are you currently or regularly taking any medications, tablets, special diets or injections		
Are you pregnant		
Is there any aspect of your medical history which an employer should or might wish to know		
Would you require any adjustment to your working environment to undertake your chosen occupation		
Do you have any conditions of vision, hearing or speech which might effect your ability to work		
Have you ever suffered from any mental illness / depression or alcoholism or drug dependency		
Are you attending any hospital for treatment or are you currently on a waiting list for treatment		

Do you now, or have you ever, suffered from or received treatment for:

Respiratory (including asthmatic or allergic) symptoms, disorders or diseases		
Cardiovascular symptoms, disorders or diseases		
Gastrointestinal symptoms, disorders or diseases		
Neurological (including epileptic) disorders or diseases		
Psychiatric symptoms		
Genitourinary disorders or diseases		
Skin symptoms disorders or diseases including reaction to gloves & glove powder		
Endocrine (including diabetic) symptoms disorders or diseases		
Haematological symptoms disorders or diseases		
Recurrent sore throat (including any treatment required for MRSA infections)		
Bone or joint symptoms disorders or diseases (including back pain)		
Imunno-deficiency symptoms e.g HIV positive disorders or diseases		
Stress related disorders or diseases		
Alcohol / drug related symptoms, disorders or diseases		
Overseas travel symptoms, disorders or diseases		

Details:

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Immunisation History:

Have you had any of the following immunisations?

	Yes	No	Date
Diphtheria			
Poliomyelitis			
Tetanus			

*** You must send us the following:**

VARICELLA

In the space below please indicate if you have immunity from Varicella
I confirm that I have contracted chicken pox or shingles in the past.

Signed.....Date.....

TUBERCULOSIS

We require an occupational health / GP certificate of a positive scar or a record of a positive skin test result.

Have you worked in a TB prevalent area, where HIV is also prevalent in the last 3 years?

YES	NO	DATE

If yes please state where and for how long

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RUBELLA:

Certificate of vaccination or blood test is required showing rubella immunity

Hepatitis B

You must provide a copy of a recent pathology report showing a titre level above 100lu/l or a positive antigen status if titre level below 100lu/l. the report must be an identified validated sample.

Hepatitis C

Proof of hepatitis C non-infectivity is required for staff performing exposure prone procedures; therefore please provide an identified validated sample of your most recent UK pathology report

DECLARATION:

The information supplied is true to the best of my belief. I agree to inform my employers of any health problems so that my health and safety can be protected whilst at work

Name:.....

Signature:.....

Date:.....