

Pre-Employment Medical Questionnaire

Personal details:

Post applied for:		Department:	
Surname:		Forenames:	
Date of Birth:		Age:	
Gender:		Telephone:	
Height:		Weight:	
Address:			
Name and address of GP:			
Do you smoke?			
What is your weekly consumption of alcohol?	t		

Occupational history:

Has your employment ever been terminated on the grounds of ill health?	
Approximately how many days/weeks sickness absence did you have in the last 12 months?	

Medical history:

Are you currently taking prescribed medicine:		<input type="checkbox"/> yes <input type="checkbox"/> no	
Are you currently under the care of a doctor or other medical professional:		<input type="checkbox"/> yes <input type="checkbox"/> no	
Are you currently suffering from or have suffered from any of the illnesses listed below:			
Allergies	<input type="checkbox"/> yes <input type="checkbox"/> no	Asthma	<input type="checkbox"/> yes <input type="checkbox"/> no
Back/neck problems	<input type="checkbox"/> yes <input type="checkbox"/> no	Depression/anxiety	<input type="checkbox"/> yes <input type="checkbox"/> no
Diabetes	<input type="checkbox"/> yes <input type="checkbox"/> no	Fits/blackouts/epilepsy	<input type="checkbox"/> yes <input type="checkbox"/> no
Headaches/migraines	<input type="checkbox"/> yes <input type="checkbox"/> no	Hearing/sight problems	<input type="checkbox"/> yes <input type="checkbox"/> no
Heart trouble	<input type="checkbox"/> yes <input type="checkbox"/> no	Hernia or rupture	<input type="checkbox"/> yes <input type="checkbox"/> no
High blood pressure	<input type="checkbox"/> yes <input type="checkbox"/> no	Jaundice/hepatitis	<input type="checkbox"/> yes <input type="checkbox"/> no
Joint Problems	<input type="checkbox"/> yes <input type="checkbox"/> no	Kidney/bladder disorder	<input type="checkbox"/> yes <input type="checkbox"/> no
Lung disease	<input type="checkbox"/> yes <input type="checkbox"/> no	Mobility problems	<input type="checkbox"/> yes <input type="checkbox"/> no
Serious accident	<input type="checkbox"/> yes <input type="checkbox"/> no	Severe stress reaction	<input type="checkbox"/> yes <input type="checkbox"/> no
Skin problems	<input type="checkbox"/> yes <input type="checkbox"/> no	Stomach/bowel trouble	<input type="checkbox"/> yes <input type="checkbox"/> no
Surgical operations	<input type="checkbox"/> yes <input type="checkbox"/> no		
<p>If you have answered “yes” to any questions in the Medical History section– please give details and approximate dates where relevant. This is particularly important where you have a qualifying disability under the Disability Discrimination Act 1995, as it will enable us to identify what, if any “reasonable adjustments” can be made.</p>			

I hereby declare that the information given is full and true to the best of my knowledge. I understand that if, at a later date, it is discovered that I have knowingly withheld medical information, disciplinary action may be taken against me, which may include dismissal.

Signature: Date: