

Occupational Health Questionnaire

MEDICAL HISTORY

Please complete the whole form in **BLOCK CAPITALS**

Surname:

Reference No: (Office use)

First name:

Gender: Male Female

Speciality:

Date of birth:

Grade:

National Insurance no:

Please answer **all** of the following questions Have you ever had or do you now have any of the following? **YES** **NO**

	YES	NO
1. An impairment, which may affect your ability to work safely or perform your duties?		
2. Eyesight problems not corrected with glasses or contact lenses or ailments affecting the eyes?		
3. Hearing problems not corrected with a hearing aid or ailments affecting your ears?		
4. Difficulty in standing, bending, lifting or other movements?		
5. Do you have any kind of skin problem? e.g. eczema; dermatitis etc.		
6. Have you ever knowingly been in contact with MRSA or worked in an MRSA environment? Are you aware of MRSA guidelines and the need for screening?		
7. Do you suffer from rheumatism, arthritis, gout, backache, 'disc' trouble, or rheumatic fever.		
8. Suffered significant discomfort when using a keyboard? e.g. blurred vision, headache etc.,		
9. Any psychiatric or psychological conditions, including stress at work?		
10. Fainting attacks, fits, blackouts, epilepsy or any disease of the nervous system.		
11. Do you suffer from any allergies?		
12. Any accidents, which have significantly affected you physically or mentally?		
13. Persistent cough, asthma, pleurisy, bronchitis or any other ailment of the lungs or chest.		
14. Have you or have you ever been infected with tuberculosis (TB)? Have you had chest x-ray in the past 12 months?		
15. In the last 12 months have you had a cough for more than 3 weeks, ever coughed up blood or experienced any unexplained loss of weight or fever?		
16. Indigestion, diarrhoea, gastric or duodenal ulcer, gall stones or any ailment of the stomach, intestines or liver.		
17. Diabetes, anaemia or any blood or gland condition.		
18. Palpitations, shortness of breath, chest pains, raised blood pressure or other ailments of the heart or circulatory system.		
19. Any ailment affecting the kidneys or bladder?		
20. Have you seen a doctor in the last five years?		
21. Any injury, operations or physical ailment?		
22. Have you been prescribed any medical treatment or medication in the last 5 years? (Give name of drugs & dosage)		

WORK PROFILE

Please tick the areas below that you believe are appropriate to the position (s) you are applying for:

- | | | | |
|---|-----------------------|--|-----------------------|
| Working in confined spaces | <input type="radio"/> | Night work | <input type="radio"/> |
| Exposure to chemicals | <input type="radio"/> | Shift rotation | <input type="radio"/> |
| Contact with client for personal care | <input type="radio"/> | Driving | <input type="radio"/> |
| Exposure to blood and/or body fluids | <input type="radio"/> | Moving and handling of clients | <input type="radio"/> |
| Exposure Prone Invasive Procedures (EPIP) | <input type="radio"/> | Moving and handling of other objects | <input type="radio"/> |
| Pharmacy | <input type="radio"/> | Radiation | <input type="radio"/> |
| Food handling | <input type="radio"/> | Substantial access to children | <input type="radio"/> |
| Working at heights | <input type="radio"/> | Visual display screen user (over 1 Hr/ day continuous) | <input type="radio"/> |

Please identify any other significant hazards you may be aware of:

In relation to Night Shift Work, please explain in the space provided below, if YES

2. Have you ever felt that night work was harming your health? Yes No

1. Do you consider that you have medical condition that might affect your ability to work at night? Yes No

IMMUNISATIONS & BLOOD TESTS

Certain jobs carry with them a risk of infection. As a Simmans Medical Agency healthcare worker, you are required to have certain immunizations to prevent the risk of any infection and we require documented immunity evidence before employment commences.

Please provide details below of your immunization history and enclose any relevant certificates or laboratory reports.

	YES	NO	DATE	TEST RESULTS ATTACHED
Tetanus				Not required
Poliomyelitis				Not required
Diphtheria				Not required
Hepatitis B (showing titre levels >100)				
Hepatitis C				
Rubella (German Measles)				
Have you ever had Varicella (Chicken Pox)?				Not required
If NO, provide details of immunity test or vaccination course				
BCG (Tuberculosis vaccinations)				
If NO, have you had a Tuberculosis test (e.g. Heaf or Mantoux) within last 5 years?				
If YES, do you have evidence of a BCG scar?				Not required
If you have a scar please get a doctor or nurse to sign as having witnessed your scar, giving their name, qualifications and date. NB:-BCG MARK CAN BE VERIFIED DURING INTERVIEW.				

OTHER, please give details below: (continue on a separate sheet if necessary).

G.P HEALTH ASSESSMENT

INFORMATION FOR GENERAL PRACTITIONER

Please give details of GP

Name:

Address:

Telephone No:

Fax No:

I agree that you may need to contact my G.P. if necessary

Signed:

Date: --

The above named person has applied to work for Simmans Medical being the trading name of Simmans Recruitment Limited and as such will not be covered by any single occupational health department. In order to ensure the safety of the patients they will be working with and for the applicant's own Clothier report, which followed the Beverley Allett case, you are asked to verify that to the best of your knowledge this individual is suitable to work with vulnerable people as well as children within the Healthcare Sector

DECLARATION

I acknowledge that I have been given a copy of the terms and conditions of service issued Simmans Medical the trading name of Simmans Recruitment Limited, which is mine to keep, and furthermore that I have read those terms and conditions and agree to abide by them.

I declare that I will hereby inform Simmans Medical the trading name of Simmans Recruitment Limited of any changes in my health circumstances which may affect my ability to work whilst registered with Simmans Medical.

I am not aware of any condition, medical or otherwise, which would affect or limit my employment or performance, other than those declared in my Occupational Health Form.

I am permitted to work in the UK. I understand that my registration is subject to the receipt of at least two satisfactory references and enhance disclosure from the Criminal Records Bureau.

I appoint Simmans Medical to undertake my CRB Enhance disclosure; however, charges are to be borne by me.

I declare that the information given herein is true and complete and is not presented in a way intended to mislead. I agree that if I have given false or misleading information or omit to give relevant information now or in the future, that Simmans Recruitment Ltd T/A Simmans Medical may cease to offer me further agency placements without notice, as well as a claim for recovery of any payments I have received, together with a claim for loss of profit to Simmans Medical.

I acknowledge that my personal details will be stored and handled correctly by Simmans Medical in accordance with the Data Protection Act 1988, however, I agree that they may be made available for audit by the relevant Government Organisations, e.g. NHS PASA or the National Care Standards Commission

I undertake to inform Simmans Medical immediately if I am engaged through introduction, or if during the course of a temporary assignment, the Client wishes to employ me direct, I acknowledge that Simmans Medical will be entitled either to charge the client an introduction / transfer fee, or to agree an extension of the hiring period with the Client (after which I may be employed by the Client without further charge being applicable to the Client).

I agree to respect the confidentiality of patients and any other information I may have access to, at any time.

Signature: Print Name:

Date: NMC Pin Number: