Work Health Questionnaire

Before completing this form please read this page

Who completes what?

SECTION ONE - Manager/Appointing Officer

SECTION TWO A & B - Successful candidate

SECTION THREE - Successful candidate who has declared health issues

COSHH RISK ASSESSMENT

Service users contact

Driving (except to and from main place of work)

Manual handling or postural demands

The use of Display Screen equipment

Vulnerable groups of service users

Staff who may be at risk of infection with the following has been assessed under COSHH and is considered significant, warranting protection of the employee by vaccination in spite of other measures taken.

Staff who have face-to-face contact with Service Users

Those staff whose employment requires them to transport clients or supplies on behalf of their Employer

This includes Service user handling, lifting, carrying and lowering, repetitive bending and twisting, prolonged standing, or maintaining an awkward posture.

This involves continuous periods of an hour or longer per day where the worker has little or no discretion on when or whether to use the screen for their work.

This may include staff who are required to work with service users, the elderly or service users with mental health problems

Applicant Name Date of birth:

SECTION ONE

APPOINTING OFFICER/MANAGER TO COMPLETE THIS SECTION

You **MUST** complete all of the information in Section one. Send/give this form to the successful **applicant only** (not to short listed applicants). Any offer of employment should be made subject to a satisfactory health assessment.

Details of absence records should be requested when taking up references from previous employers.

Applicant Name:

Mr/Mrs/Miss/other **Date of Birth:** **Gender:**

Previous/Birth Surname:

Home Tel No:

Address:

Email Address:

Mobile /Contact No:

Current Location: (Employer & address)

Post Applied for: **Anticipated Start Date:**

ROLE RISK ASSESSMENT- The following activities are an integral part of the job.

1. Service user in their home

2. Exposure Prone Procedures (see appendix 1)

3. Handling patients

4. Hours: _____/week
a) nights
b) early/late
c) on-call

5. Handling loads up to _____kg

6. Driving

7. Working with pregnant women

8. Chemicals/Detergents

9. Lone Working

10. Animals (dogs, cats, birds etc.) in client home environment

Manager/Appointing Officer

Company Name

Name (please print):

Signature: Date:

Anticipated start date:

SECTION TWO (a)
To be completed by Prospective Employee:

Your Name must be entered on every sheet; this allows identification if sheets are separated (see footer).

Identify any health problems or disabilities that may make the proposed job difficult or unsafe for you or others. Enable us to assess what adjustments to the job may be needed to enable you to work, if you have a health problem or disability.

Please read the following questions carefully, and then tick whichever of the two statements is appropriate for you and sign the declaration below. To preserve medical confidentiality you are **not required to identify any conditions/illnesses you may or may not have on this part (section two) of the form.**

SECTION two - To be completed by Prospective Employee:

Do you have any condition or disability that could affect your ability to undertake any of the activities of the proposed post, including shift patterns, without adjustments? **YES/NO**

Have you ever had any illness / impairment / disability which may have been caused or made worse by your work? **YES/NO**

Has your work (hours or duties) ever been modified or have you had to leave a job because of a health problem? **YES/NO**

Have you ever been affected by one of the following health problems:

Diabetes? **YES/NO** Epilepsy? **YES/NO**
Musculoskeletal problems or back pain? **YES/NO**
Skin disorders, e.g. hand eczema? **YES/NO**
Chest problems, e.g. asthma? **YES/NO**
Heart, circulation or blood pressure problems? **YES/NO**
Impairments of vision (other than to wear glasses)? **YES/NO**
Impairments of hearing? **YES/NO**
Depression, psychiatric or nervous/stress problems? **YES/NO**
Substance or alcohol misuse? **YES/NO**
Any other problem that you may wish to bring to the attention of Dementia Care TLC **YES/NO**

DECLARATION- SECTION TWO (a)

None of the above applies to me.

1. **YES** ☒ I would answer YES to one or more of the above questions. **ACTION** – Please sign below and complete section 3

2. **NO** ☒
ACTION – please sign below and return to Dementia Care TLC

* In signing this questionnaire you confirm that all the information provided is true to the best of your knowledge true and correct. If it is subsequently shown that medical information has not been disclosed by you, or has been misleading or false, the offer of employment may be withdrawn, or you may be subject to disciplinary proceedings, which could result in dismissal.

Name (Block capitals):……

Signature:
……Date:……..

If you have declared 'YES' to any of the above questions then you MUST complete Section three.

Do you consider that you have a disability? YES/NO If 'YES', please give details.

Details of Disability Details of adjustment you consider may be required for you to Undertake the position Certain lifestyle factors are associated with future poor health.

Please answer the following for your own benefit:

Are you overweight for your height?

Do you smoke?

Do you exercise for 20 minutes three times weekly to the point where your pulse and breathing are speeded up?

Would you like advice to improve this? **YES/NO**

For night workers only A&B i.e. staff whose duties include 3 hours or more between 10 p.m. and 7 a.m.

Do you suffer from:

A) Any medical condition affecting sleep? **YES/NO**

B) Any chronic chest disorders where night time symptoms may be particularly troublesome? **YES /NO**

Dates Details of condition and treatment

CONSENT & STATEMENT ***

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Signed:

Date:

Do you suffer from or have you ever had any of the following: If "**YES**" please give details:
extra space is available on the last sheet for this.

Severe or prolonged headaches, migraines or face pains? **Yes/No**

Eye Disease? **Yes/No**

Colour Blindness? **Yes/No**

Do you wear spectacles or contact lenses? Please indicate which you use?

Reason?

Ear trouble, disease or hearing problems? **Yes/No**

Have you ever had a noisy hobby e.g. shooting? **Yes/No**

Have you ever worked in a noisy environment? **Yes/No**

Do you wear a hearing aid(s)? **Yes/No**

Epilepsy, fainting attacks, blackouts or attacks of giddiness? **Yes/No**

Chest Disease: bronchitis, pneumonia, pleurisy, asthma etc.? **Yes/No**
Please indicate all that apply.

Raised blood pressure? **Yes/No**

Heart or circulatory problems? **Yes/No**

Back or neck deformity, disease, injury or pain, whiplash, sciatica etc.? **Yes/No**

Rheumatism, arthritis or joint or muscle problems? **Yes/No**

Bladder, kidney or urinary problems? **Yes/No**

Blood disorders, hepatitis, anaemia, jaundice? **Yes/No**

Diabetes (recent onset or childhood) Psychiatric illness or nervous trouble? **Yes/No**

Stress, depression or anxiety even if mild? **Yes/No**

Eating problems or disorder including Anorexia, Bulimia or others? **Yes/No**

Alcohol, drugs or substance use/misuse? **Yes/No**

Stomach or digestive problems e.g. ulcer, hiatus hernia, gallstones, Celiac disease? **Yes/No**

Any skin problems e.g. dermatitis, eczema, psoriasis?

Any allergies e.g. to drugs, latex, nuts, fruits, animals, hayfever etc? **Yes/No**

Have you or any near relative suffered from Tuberculosis (TB)? **Yes/No**

Have you ever had or do you have a persistent cough, weight loss, night sweats or coughed up blood? **Yes/No**

Details (dates, diagnoses, restrictions on your activities, treatment, duration, recovery)

Any other illness or injury i.e. road traffic accident or attendance at A & E Department?

SECTION THREE CONSENT & STATEMENT ***

* In signing this questionnaire you confirm that all the information provided is true to the best of your knowledge true and correct. If it is subsequently shown that medical information has not been disclosed by you, or has been misleading or false, the offer of employment may be withdrawn, or you may be subject to disciplinary proceedings, which could result in dismissal.

I understand that should additional information be required, GP Choices occupational health will notify me of their request by phone or in writing, if following contact and or consultation a report or disclosure is required.

Signed:

Date: