



## Pre-employment health questionnaire

Private and Confidential

**Please complete and return this form as directed.**

The health of each candidate is considered individually and no decision to reject a candidate on medical grounds will be made without a medical examination or medical advice being sought.

You should notify us immediately if you have any serious illness after completing this form and before you take up the appointment offered as a result of your application.

If you give any information that you know is false – or you withhold any information – your application may be rejected (or, if already appointed, you may be dismissed).

### SECTION ONE – RECRUITMENT – TO BE COMPLETED BY THE EMPLOYER

Company:

Department:

Name of person responsible for recruitment:

Name and contact telephone number of person to whom medical clearance should be returned:

Job title/position applied for:

Typical tasks associated with this job:

In which department will the employee be working?

Proposed date of joining company:

**Please tick boxes regarding job hazards**

		None	<input type="checkbox"/>
Heavy Physical work or manual handling	<input type="checkbox"/>	Repetitive upper limb movements	<input type="checkbox"/>
Extremes of temperature	<input type="checkbox"/>	Noisy Environment	<input type="checkbox"/>
Respiratory or skin hazards	<input type="checkbox"/>	Vocational driving (HGV/LGV/PCV/Forklift)	<input type="checkbox"/>
High mental demands	<input type="checkbox"/>	Night work	<input type="checkbox"/>

Other hazards – especially other chemical hazards – please specify

## SECTION TWO – TO BE COMPLETED BY THE EMPLOYEE

Surname

Date of Birth

Forename

Male

Female

Home address

Post code

Preferred Contact  
telephone number

## SECTION THREE – MEDICAL HISTORY/DETAILS

**Do you, or have you ever suffered from any of the following**

(For questions 3.1 to 3.12 inclusively, indicate if you have ever suffered from any of the **following** conditions by underlining the appropriate condition **and providing details** in the comments box on the back page).

- |   | <b>Yes</b>               | <b>No</b>                |
|---|--------------------------|--------------------------|
| <b>3.1</b> tuberculosis, pleurisy, asthma, bronchitis, or any other lung, throat or ear complaint, including deafness.  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>3.2</b> any disorder of the heart, circulatory system, high blood pressure   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>3.3</b> persistent indigestion, gastric or duodenal ulcer, intestinal complaint or rupture                           | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>3.4</b> epilepsy or fits   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>3.5</b> any psychological or nervous complaint   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>3.6</b> diabetes, gout or any kidney or bladder complaint  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>3.7</b> any arthritis, slipped disc, rheumatism, back trouble or upper limb problem                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>3.8</b> dermatitis, other skin complaint or allergic condition   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>3.9</b> sleep apnoea, narcolepsy or cataplexy  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>3.10</b> frequent headaches or migraine  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>3.11</b> any eye complaint including blurred vision or eye discomfort  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>3.12</b> any other significant medical problem?<br>(excluding coughs/cold/flu or any of the conditions listed above) | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>3.13</b> Do you normally wear glasses or contact lenses  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>3.14</b> When did you last have any eyesight test? .....   | .....(month)             | .....(year)              |

**If you answer 'Yes' to questions 3.15 to 3.20 please provide details in the comments box on the back page**

- |  | <b>Yes</b>               | <b>No</b>                |
|--|--------------------------|--------------------------|
| <b>3.15</b> Do you have any difficulty in recognizing different colours?                             | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>3.16</b> Have you ever failed a medical examination of any kind?                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>3.17</b> Have you ever consulted, or been recommended to consult a medical specialist             | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>3.18</b> Have you ever been in hospital as a patient? ( <b>please provide details on page 4</b> ) | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>3.19</b> Are you currently on any treatment being prescribed by a Doctor?                         | <input type="checkbox"/> | <input type="checkbox"/> |

**(If you answer ‘Yes’ to question 3.20, you may be sent a supplementary health questionnaire for completion so that the medical staff can assess appropriate and reasonable work adjustments for you)**

- |  |                          |                          |
|--|--------------------------|--------------------------|
| <b>3.20</b> With reference to the Disability Discrimination Act, do you have any physical or mental Impairment, which significantly affects your daily living? | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>3.21</b> Are you pregnant?  | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, how far are you into the pregnancy?  | .....(months)            |                          |

#### **SECTION FOUR – OCCUPATIONAL HISTORY/DETAILS**

- |  | <b>Yes</b>               | <b>No</b>                |
|--|--------------------------|--------------------------|
| <b>4.1</b> Have you ever worked for the company before?  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>4.2</b> How many jobs have you had since you started work?  | .....                    |                          |
| <b>4.3</b> What industries have you worked in before applying for this job?<br><i>For example Machine operator for light engineering company</i> | <i>1985-1989</i>         |                          |
| _____  | _____                    |                          |
| _____  | _____                    |                          |
| _____  | _____                    |                          |

**For questions 4.4 to 4.8 inclusive – ‘Have you ever worked.....**

- |   |                          |                          |
|---|--------------------------|--------------------------|
| <b>4.4</b> in a dusty environment?                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>4.5</b> in a noisy environment?                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>4.6</b> with chemicals?  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>4.7</b> with x-rays or other forms of radiation?                 | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>4.8</b> with vibrating tools?                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>4.9</b> had a repetitive strain injury or an upper limb problem? | <input type="checkbox"/> | <input type="checkbox"/> |

- 4.10 had any problems related to alcohol?
- 4.11 had any problems related to the use of illegal or prescribed drugs?
- 4.12 had any disease or injury arising out of your work e.g. deafness, backache, dermatitis, asthma or vibration white finger?
- 4.13 been advised for medical reasons not to do night work, shift work, or any other kind of work?
- 4.14 undergone health surveillance due to hazards in your previous job?
- 4.15 Are you in receipt of a disability pension?
- 4.16 What is your height? .....feet/ins / metres      4.17 What is your weight? .....stone/kgs

- 4.18 Do you smoke?       No    Yes      If Yes....how many per day?  
(cigarettes/cigars/pipes) .....
- 4.19 Do you drink alcohol?  No    Yes      If Yes....what is your average .....units per week  
weekly intake?  
(½ pint/glass wine/measure spirit = 1 unit)

**4.20 SICKNESS ABSENCE**  
**Within the past 12 months**

How many days have you been unable to attend work/studies or undertake normal daily living tasks, through sickness? .....

How many episodes of sickness absence have you had? .....

**Please use the text box to indicate the cause of any absence that you have had.**

If you have answered “yes” to any questions on page 2 or 3 of this questionnaire, with the exception of questions 3.13, 3.14 & 3.21 or 4.1, 4.18 & 4.19, please give details in the space below, continuing on a separate sheet of paper if necessary, and include:

- The date that the problem occurred and whether the condition is still present
- Details of any medication used or treatment undertaken in connection with the condition, and
- Details of any other medical condition not referred to within this questionnaire.

**GDPR Clause and Declaration – Pre-employment health questionnaire**

Under the GDPR 2018 legislation, the information you supply about yourself in this form is known as your personal data and information about your health, medical history and any treatment you have received is called “sensitive personal data”. The form including your “sensitive personal data” may be used by H&B Medical (OH) to assess whether you are fit for the post for which your application is being considered. Your consent is required before this processing can take place. Please see the declaration below.

**SECTION FIVE – DECLARATION**

**PLEASE READ CAREFULLY.** By signing this declaration you will be giving your consent to the processing of the information you have supplied. If you do not understand the content of this form, the content or effect of the declaration or you feel unable to give your consent, please contact the person responsible for recruitment mentioned on part 1 for further information.

I CONFIRM THAT I HAVE READ AND UNDERSTOOD THE DATA PROTECTION NOTICE ABOVE. I HEREBY AGREE AND CONSENT TO THE PROCESSING OF THE INFORMATION THAT I HAVE SUPPLIED ABOUT ME. I declare that all the foregoing statements are true and complete to the best of my knowledge and belief and I am not aware of any other medical condition not referred to elsewhere in this questionnaire. I understand that any misrepresentation will invalidate my application and if employed, could lead to my dismissal.

I understand that I may be required to undergo a medical examination by the company’s appointed medical adviser for pre-employment purposes only.

<b>Your signature:</b>	<b>Date :</b>
------------------------	---------------

**SECTION SIX – DO NOT WRITE IN THIS SECTION OF THE QUESTIONNAIRE**

**Initial review of PEHQ and further action required**

---

- |   |  |
|---|--|
| <input type="checkbox"/> Obtain further information | <input type="checkbox"/> Obtain consultant report          |
| <input type="checkbox"/> Obtain GP report           | <input type="checkbox"/> Arrange IMA                       |
|   | <input type="checkbox"/> Issue DDA questionnaire (OHS 150) |

**Final Conclusion**

- |   |  |
|---|--|
| <input type="checkbox"/> <b>Fit</b> for position  | <input type="checkbox"/> <b>Unfit</b> for position |
| <input type="checkbox"/> Employee covered by DAA  |  |
| <input type="checkbox"/> Fit for employment in a limited capacity <i>or</i> amendments to the working environment should be considered (see below). |  |

Comments:

<b>Clinician:</b>	<b>Date:</b>
-------------------	--------------