## HEALTH QUESTIONNAIRE FORM

Please give full details in the space provided of the dates, duration and outcome of the illness or condition. Please also be aware that you must inform your **line manager** immediately if your health changes significantly or if any responses to the following questions change after you submit.

Have you ever had: Yes No

Tuberculosis, Asthma, Bronchitis or chest complaints? 🞎 🞎

|  |
| --- |
| Additional information: |

Chest pain, heart condition or raised blood pressure? 🞎 🞎

|  |
| --- |
| Additional information: |

Blackouts, fits or attacks of giddiness? 🞎 🞎

|  |
| --- |
| Additional information: |

Depression, Mental health needs/problems? 🞎 🞎

|  |
| --- |
| Additional information: |

Rheumatism or Arthritis? 🞎 🞎

|  |
| --- |
| Additional information: |

Back trouble? 🞎 🞎

|  |
| --- |
| Additional information: |

Typhoid, Diphtheria, Paratyphoid or Dysentery? 🞎 🞎

|  |
| --- |
| Additional information: |

Digestive or bowel disorder? 🞎 🞎

|  |
| --- |
| Additional information: |

Diabetes, Thyroid or other gland trouble? 🞎 🞎

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| --- |
| Additional information: |

Bladder or Kidney trouble? 🞎 🞎

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| --- |
| Additional information: |

Dermatitis or skin trouble? 🞎 🞎

|  |
| --- |
| Additional information: |

Varicose veins? 🞎 🞎

|  |
| --- |
| Additional information: |

Any other accident, operation or illness? 🞎 🞎

|  |
| --- |
| Additional information: |

Have you any reason to believe you may be infected by any communicable disease?

 🞎 🞎

|  |
| --- |
| Additional information: |

Any other current or recent medical condition or treatment that may affect your attendance or performance at work? 🞎 🞎

|  |
| --- |
| Additional information: |

Any illness or medical condition that prevented you from attending work or your normal duties or activities for more than one week during the past year? 🞎 🞎

|  |
| --- |
| Additional information: |

Any physical disabilities including defect of sight or hearing? 🞎 🞎

|  |
| --- |
| Additional information: |

Do you have any life-threatening allergies i.e. Bee stings, nuts? 🞎 🞎

|  |
| --- |
| Additional information: |

## HEALTH DECLARATION

## Please select which of the following statements apply to you i.e. tick *either* statement A or B:

|  |  |
| --- | --- |
| I am not aware that I have a health condition or disability that might impair my ability to undertake the duties effectively for the position that I have been offered.  |  |
| I do have a health condition or disability that might affect my work and may require special adjustments to my work or my place of work.  |  |

## Have you received vaccination for any of the following?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Y | N | Date of Vaccination |
| Tuberculosis BCG |  |  |  |
| Measles |  |  |  |
| Mumps |  |  |  |
| Rubella (German Measles) |  |  |  |
| Tetanus |  |  |  |
| Flu |  |  |  |
| Diphtheria |  |  |  |
| Polio |  |  |  |
| Hepatitis B - Please provide certificate of vaccination and immunity |  |  |  |
| Chicken Pox  |  |  |  |

## I certify with applicable documentation that I am fit for work in the care industry

## Print Name: ………………………………………………………………………………………………………………………………………

## Signed: ………………………………………………………………………………………………………………………………………

## Date: ………………………………………………………………………………………………………………………………………

## This section to be completed by Associates Healthcare cic management:

## I certify that I am satisfied to the best of my knowledge that this employee is fit to undertake work in the care industry due to the selections made and information provided above.

## Manager/Interviewer:

## Print Name: ………………………………………………………………………………………………………………………………………

## Signed: ………………………………………………………………………………………………………………………………………

## Date: ………………………………………………………………………………………………………………………………………