



# Pre Employment Health Questionnaire

Prepared: 21/05/2009	Approved by: MSands	Approval date:9/7/09
Version: 2	Last modified: 23/2/10	Reference: FCC059-R5
Review due: Feb 2011		

Please read this form all the way through before starting to complete it and answer all of the sections. The purpose of this questionnaire is to assess your medical fitness for employment in order to protect your own and others health and safety.

The information provided on this form will remain strictly confidential. The form when completed should be sent in the envelope provided direct to:

Maria Sands  
 Registered Manager  
 Family Circle Care Ltd  
 22 Tower Street  
 Edinburgh  
 EH6 7BY

**PERSONAL DETAILS**

Surname:

First names:

Male/ Female:

Address:

Contact telephone numbers:

Home:

Mobile:

Name and address of your Doctor:

<b>Name</b>	
<b>Address</b>	
<b>Telephone No</b>	

**DETAILS OF POST APPLIED FOR**

Title of post applied for:

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**ABSENCE RECORD**

Have you had any absences due to illness during the last two years?

If yes, please give details:

Date	Duration	Reason

**GENERAL INFORMATION**

Do you smoke?		If yes, how many a day?	
Do you drink alcohol?		If yes, how many units per week?	
What is your height?		What is your weight?	

**MEDICATION**

Are you currently taking any prescribed medication?

If yes, please give details:

**MEDICAL HISTORY**

Please answer all of the following questions. If the answer is yes, then please give details.

- Have you ever had any hospital treatment or operations in the last 12 months? Yes/ No
- Have you seen a doctor in the last 6 months? Yes/ No  
If yes, please provide details

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3. Are you on any waiting lists for further medical investigations or treatment? Yes/ No
4. Do you have any health problems which may affect your ability to work safely? Yes/ No
5. Have you ever had any health problems which may have been caused or made worse by work? Yes/ No
6. Do you have any allergies? Yes/ No
7. Do you have any problems with your eyes or vision that cannot be corrected by glasses? Yes/ No
8. Do you have any ear, nose or throat problems including hearing difficulties? Yes/ No
9. Do you have or have you ever suffered from any kind of neck or back problem? Yes/ No
10. Do you have or have you ever suffered from any kind of problem with your joints including pain, swelling or stiffness? Yes/ No
11. Do you have or have you ever suffered from any kind of skin problem? Yes/ No
12. Do you have or have you ever suffered from problems affecting your circulation? Yes/ No
13. Do you have or have you ever suffered from asthma, bronchitis or chest problems? Yes/ No
14. In the last twelve months have you had a cough for more than 3 weeks, coughed up blood or had any unexplained weight loss or fever? Yes/ No
15. Do you have or have you ever suffered with hepatitis or jaundice? Yes/ No
16. Do you have or have you ever suffered from diabetes, thyroid or gland problems? Yes/ No

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17. Do you have or have you ever suffered from fits, blackouts or epilepsy? Yes/ No
18. Do you have or have you ever suffered from any mental illness, or psychological problems, including stress, depression, anxiety, eating disorders etc.? Yes/ No
19. Do you have or have you ever suffered from drug or alcohol problems? Yes/ No
20. Have you ever been medically retired from another job? Yes/ No
21. Do you have or have you ever suffered from any other medical conditions? (other than childhood ailments) Yes/ No
22. Do you have any other health problem not already mentioned? Yes/ No
- If yes, please provide details

**DECLARATION**

I certify that I have answered the above questionnaire honestly and fully and that I am mentally and physically fit to work. I realise that any false statements could result in my offer of employment being withdrawn. If any statements are found to be false during my employment, my employment may be terminated without notice. I understand and accept that further medical information may be requested from my doctor if considered necessary and subject to the Care Manager obtaining my consent.

Signature of applicant:

Date:

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