A & T Caring Services

Health screening questionnaire

(Note to employer: this form must not be used as part of the recruitment process)

(Private & Confidential)

This form should be completed by the employee and returned to your employer.

The information provided on this form will be used by the organisation to determine if it is safe for you to undertake a work task or if the activities that you are required to undertake will exacerbate any pre-existing medical conditions. The form will be handled in strict confidence and all information stored according to the requirements of the Data Protection Act.

Based on the information provided, we may need to seek advice from a doctor, or occupational health specialist. It may also be necessary for you to regularly attend health surveillance during your employment if determined by the company risk assessments or medical practitioner. Advice regarding fitness for work will be accessible to management in general terms, however, detailed clinical information will not be revealed without your consent.

If further information is required from your doctor or health specialist, this will only be obtained with your written consent.

SECTION A. Personal Details	
SURNAME:	Forename/s:
Address:	
TEL:	Email:
Name and address of personal doctor:	
Position:	

SECTION B. Job involves	
☐ Regular manual handling/lifting duties	☐ Regular overseas Travel
☐ Human blood, tissues, fluids	☐ Regular Display Screen Equipment (DSE) usage
☐ Respiratory sensitisers or allergens	☐ Latex materials
☐ Use of isocyanate based products	☐ Food handling
☐ Regular vehicle driving activities (incl. fork lift trucks)	☐ Regular night shifts
☐ Working at height	☐ Lead
☐ Ionising radiations	☐ Vibrating equipment
☐ Noisy environments	☐ Other hazards (please state):-

SECTION C. Health history	
Do you have, or have you previously had, any of the following health conditions?	**YES/NO**
• Giddiness, fainting attacks, epilepsy	• Stroke, heart trouble, high blood pressure or varicose veins
• Mental illness, anxiety or depression	• Diabetes
• Recurring headaches	• Skin trouble
• Serious injury or operations	• Ear trouble or deafness
• Serious hay fever, asthma or recurring chest infections	• Colour vision or eye trouble not corrected by glasses or contact lenses
• Recurring stomach or bowel trouble	• Back or muscle/joint trouble
• Recurring bladder trouble	• Hernia or rupture
How many days have you been absent from work in the last three years because of illness or physical injury?	YES/NO
Are you currently taking any prescribed medication?	YES/NO
If you answer "yes" to the above questions, you may be asked to see a doctor or nurse for further assessment.	

SECTION D. Disabilities		
Do you have any disabilities that affect the following?		**YES/No**
• Standing	• Lifting	• Working at Heights
• Walking	• Using your hands	• Climbing Ladders
• Climbing stairs	• Driving a vehicle	.Working on staging
If you answer "yes" to the question, you may be asked to see a doctor or nurse for further assessment.		

SECTION E. Declaration			
I confirm that to the best of my knowledge and belief, the above information is correct. I understand that any failure to disclose information could lead to a re-assessment of my general fitness, which could ultimately lead to the termination of my employment.			
Name (BLOCK CAPITALS):		Date:	
Signature:			

Employer's comments, including details of any actions to be taken:	
Employers signature:	Date: