

ST LUKE'S HOSPICE

CONFIDENTIAL HEALTH QUESTIONNAIRE

Clinical details on this questionnaire are confidential to the Occupational Health Department. However general advice based on it will be given to the Hospice on your fitness to work.

Failure to disclose information or knowingly make a false statement may have implications for your future employment within the Hospice.

Personal Details

Surname: Dr/Mrs/Mr/Ms/Miss

First Names: Male / Female

Former/Maiden Name: Date of Birth:

Home Address:

.....

Home Telephone No: Daytime Telephone No:

GP's name: GP's Telephone No:

GP's Address:

.....

Post applied for: Department:

Permanent / Temporary YES / NO

If temporary please indicate length of contract

Employment History:

Name of employer	Post Held	Date of employment
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Please answer **EVERY** question. Tick under “YES” or “NO” as appropriate. If the answer is “YES” please give brief details.

	HAVE YOU EVER HAD:	YES Ù	NO X	BRIEF DETAILS OF ALL PAST & PRESENT CONDITIONS	DATES
1.	Severe headaches or migraine				
2.	Fits, convulsions or epilepsy				
3.	Depression, anxiety or mental ill health				
3a.	Any attempts at self-harm				
3b.	An eating disorder (e.g. anorexia, bulimia)				
3c.	Counselling, psychotherapy or psychiatric treatment				
3d.	A problem with alcohol consumption or other substance misuse				
4.	Eye conditions, injuries or serious defects of vision not corrected by lenses				
5.	Ear infections, discharge, hearing loss/deafness				
6.	Frequent sore throats or sinusitis				
7.	Asthma, hayfever, allergies (including antibiotics)				
8.	Bronchitis, pneumonia or chronic lung condition				
9.	Lung tuberculosis				
9a.	Coughing up blood				
9b.	Cough for more than 3 weeks in the last year				
10.	Heart disease, angina, raised blood pressure or circulation disorders				
11.	Blood disorders e.g. sickle cell disease, haemophilia or anaemia				
12.	Dysentery, typhoid fever, food poisoning, gastro-enteritis or chronic diarrhoea				
13.	Frequent/severe indigestion or gastric/duodenal ulcers				
14.	Hernia				
15.	Excessive weight gain or loss				
16.	Diabetes				
17.	Kidney or bladder (urinary) condition/infection				
18.	Severe back, neck pain or disc trouble				

19.	Difficulties in bending or lifting				
20.	Varicose veins or foot problems				
21.	Eczema, dermatitis or other skin conditions				
22.	Any disorder of the immune system requiring treatment with steroids				
22a.	Splenectomy				
23.	Have you ever had chickenpox?				
24.	Have you ever, to your knowledge, been infected with Hepatitis B, Hepatitis C or HIV?				
25.	Have you had any operations or are you on a hospital waiting list? (please specify)				
26.	Have you had any accident resulting in severe injury?				
27.	Are you taking any medication/drugs?				
28.	Are you attending your GP or a specialist on a regular basis?				
29.	Have you had any work related illness?				
30.	Have you ever left or changed any job due to ill health?				
31.	Do you have a disability?				
32.	Any other conditions or health problems?				

Have you had a chest X-ray? Yes/No Date: Result:

Do you smoke? Yes/No If 'yes' how many per week:

Do you drink alcohol? Yes/No If 'yes' how much per week:.....

Current weight: Current height:

Number of days/weeks absence from work in the last year due to illness or injury.

Please give reasons:

To the best of my knowledge and belief my answers to the above are true and complete. I acknowledge that failure to disclose information may result in termination of my contract.

I understand that subject to information supplied, I may be invited to attend the Occupational Health Department for an interview/further health assessment and subject to my approval, my GP/Hospital Doctor may be approached for further information.

Signed: Date:

IMMUNISATION DETAILS

Name in full: Date of Birth:

Have you been immunised against or tested for the following?

Tuberculin skin test method (e.g. Heaf)	Date:	Grade:
Tuberculosis (BCG)	Date:	Scar size in mm
Rubella (German Measles) immunisation	Date:	Result:
Rubella antibody screen	Date:	Result:
Varicella (chickenpox) antibody screen	Date:	Result:
Tetanus – Primary course dates: 1. 2. 3.	Booster dates: 1. 2.	
Polio – Primary course dates: 1. 2. 3.	Booster dates: 1. 2.	
Hepatitis B Primary course dates: 1. 2. 3.	Booster dates: 1. 2.	
Hepatitis B antibody titre date:	Result (mIU/ml)	
Typhoid – Primary course dates: 1. 2.	Booster dates: 1. 2.	
Hepatitis A Primary course dates: 1. 2.	Booster dates: 1. 2.	

ALL STAFF WHO PERFORM EXPOSURE PRONE PROCEDURES ARE REQUIRED TO SUBMIT LABORATORY DOCUMENTARY EVIDENCE OF HEPATITIS B STATUS PRIOR TO COMMENCING EMPLOYMENT

To the best of my knowledge and belief, the answers above are true and complete. I hereby give permission for the Occupational Health Department to contact my previous employer's Occupational Health Department to obtain information on past immunisation.

Signed: Date:.....

Previous post: Date left:

Hospital Name & Department:

Address:

Previous Occupational Health Department Fax No: