Medical Questionnaire

Note: This is an example form to be used by employers as an aid in drawing up their own questionnaires. The employer should ensure compliance with all relevent legislation, e.g. Data Protection Act, Equalities and Disabilities Legislation etc. Should you have any uncertainties regarding these areas, we recommend that you seek expert/legal advice before using this tool.

Full Name:

Address:

Date of Birth:

Note: The information you provide on this form will be kept entirely confidential in accordance with the ***Data Protection Act*** requirements. It will be used to assist with your own and others health, safety and welfare.

Please answer the following questions. If the answer is YES to any of the questions, then please provide full details on the attached sheet.

Do you suffer or have you ever suffered from?

1.	Epilepsy	Yes ☐	No ☐
2.	Diabetes	Yes ☐	No ☐
3.	Fits, dizziness, giddiness or blackouts	Yes ☐	No ☐
4.	Any mental illness	Yes ☐	No ☐
5.	Vertigo or ear problems	Yes ☐	No ☐
6.	Recurring eye problems	Yes ☐	No ☐
7.	Any form of deafness or ear disorder	Yes ☐	No ☐
8.	Any recurring stomach problems	Yes ☐	No ☐
9.	Any allergies	Yes ☐	No ☐
10.	Asthma, breathing difficulties, recurring chest infections, nose or throat disorder	Yes ☐	No ☐
11.	Back problems, hernias or disc injuries	Yes ☐	No ☐
12.	Problems with your lower limbs	Yes ☐	No ☐
13.	Any problems relating to repetitive work, e.g. tendonitis, tinosynovitis, carpal tunnel syndrome, tennis elbow, RSI, etc.	Yes ☐	No ☐
14.	Any symptoms of hand arm vibration or Raynaud's disease	Yes ☐	No ☐
15.	Dermatitis or skin disorders	Yes ☐	No ☐
16.	Recurring headaches or eye strain	Yes ☐	No ☐
17.	Any form of motor function disease	Yes ☐	No ☐
18.	Blood disorders	Yes ☐	No ☐
19.	Heart or other circulatory problems	Yes ☐	No ☐
20.	Arthritis or rheumatism	Yes ☐	No ☐
21.	Colour blindness	Yes ☐	No ☐
22.	Any industrial injury or disease/made a claim for same?	Yes ☐	No ☐
23.	Any condition or illness that could be aggravated by night work?	Yes ☐	No ☐

Medical Questionnaire *continued*

Have you previously been in contact with or worked with:

24.	Noisy machinery	Yes ☐	No ☐
25.	Asbestos	Yes ☐	No ☐
26.	Lead	Yes ☐	No ☐
27.	Are your currently taking any medication?	Yes ☐	No ☐
28.	Do you smoke?	Yes ☐	No ☐

Please provide additional details to any question answered with a Yes in the box below. You should also provide any additional information that you feel might be relevant.

Under the ***Disability Discrimination Act*** the company is obliged to make reasonable adjustments or adaptations that may be necessary. Are you aware of any adjustments that may be required to assist you if you are offered employment in the workplace? If yes, please detail under:

I certify that the information I have given above is true, that I have disclosed to the best of my knowledge any condition, which may affect my work and have not withheld any material fact.

I confirm that if I have any future health problems that I will immediately notify the company.

I give my ***express permission*** for the information contained in this form to be disclosed to a designated medical practitioner.

Signature: Dated:

1 Access to Medical Reports

Full Name:

Address:

Name of Doctor:

Address of Doctor:

It may be necessary to obtain a report from a doctor who has treated you. We are required to tell you about your ***statutory rights*** regarding access to medical reports, which are set out briefly below:

You may:

- refuse to allow us to obtain a report
- ask to see a report before it is sent to us
- for a charge obtain a copy from the doctor within 6 months of it being sent to us
- ask for a report you have seen to be altered by a doctor before it is sent to us, or if the doctor is unwilling to do this, you may add a statement of your own

Please note that the doctor does not have to let you see a report if he believes you or others may be harmed by it.

2 Declaration

I confirm I have read about my rights under the ***Access to Medical Reports Act*** and I authorise/do not authorise* my doctor to provide a medical report.

I wish/do not wish* to see any medical report before it is supplied.

(*Delete as appropriate)

Signature: Dated:

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