

# Small House Homes Medical Questionnaire

Small House Homes expects you to respond openly and honestly. We have been asked to point out that failure to disclose information or giving false information may result in termination of employment.

***Please complete this questionnaire and bring it fully completed with you if you attend an interview. If you are successful your completed questionnaire will be forwarded in a sealed envelope to the Human Resources Office. The interviewing manager will complete a form giving details of your job and the two forms will be submitted together for screening at Derriford Hospital, Plymouth.***

Your answers to the questions will be considered by the Occupational Health Department of Derriford Hospital and they will approach you directly if they require any further information.

All information is treated in the strictest confidence, both in screening, storage and access to records.

Small House Homes will be informed if for some reason you do not meet the criteria for being fit to work, or if a reasonable adjustment is required under the Disability Discrimination Act 1995.

The Occupational Health Department will not disclose detailed information from this questionnaire to Small House Homes without your permission. In some cases in order to ensure a safe working environment you may be advised to inform us of an existing medical condition.

Name Title

Gender - Male/Female

Address

Date of Birth

Telephone Number(s) which can be used to contact you

Home address

Name and Address of G.P

Have you travelled outside of the UK in the last year?

**Yes/No**

Please give details

Current tobacco use - per week  
Current alcohol use - units per week

***One small glass wine = 1 unit  
Half pint of beer/lager/cider = 1 unit  
Single measure (25ml) spirit = 1 unit***

Your Height -  
Your Weight -

Are you receiving any current drug treatment or have you received any drug treatment in the last twelve months? **Yes/No**

Please give details of the drug and the condition for which they were described.

Do you take regular exercise? **Yes/No**  
Details -

Do you use recreational drugs? **Yes/No**  
Current use - **Per Week**

Do you, or have you ever suffered from the following?

Any blood disorders, eg anaemia/bruising? **Yes/No**

Any musculo-skeletal disorder including back, neck, joint pain? **Yes/No**

Arthritis or rheumatism **Yes/No**

Asthma **Yes/No**

Bronchitis or other lung disorder **Yes/No**

Diabetes **Yes/No**

Ear, nose or throat disorder **Yes/No**

Epilepsy **Yes/No**

Fits or fainting **Yes/No**

Heart problems **Yes/No**

High Blood Pressure **Yes/No**

Jaundice or liver disease **Yes/No**

Kidney or bladder disease **Yes/No**

Menstrual disorders **Yes/No**

Migraine or severe headaches **Yes/No**

Multiple Sclerosis **Yes/No**

Skin conditions including eczema and psoriasis **Yes/No**

Stomach or bowel disorder **Yes/No**

**Please give details with dates if you have answered Yes to any of these**

### **Allergies**

Do you have a problem wearing latex gloves? **Yes/No**

Do you have any allergic reaction to any medicine, food or chemicals? **Yes/No**

Do you suffer from hay fever? **Yes/No**

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|--|---------------|
| <b>Mental Health</b>   |               |
| Have you ever suffered from stress, post traumatic stress, anxiety, panic attacks, depression, obsessive compulsive disorder?                          | <b>Yes/No</b> |
| Have you ever needed to see a mental health practitioner/counsellor or required medication?  | <b>Yes/No</b> |
| Have you ever self-harmed in any way?<br>(Overdose, attempted suicide or other forms of self harm).  | <b>Yes/No</b> |
| Have you ever suffered visual/auditory hallucinations or delusions?  | <b>Yes/No</b> |
| Have you ever sought advice for an eating disorder?<br>(anorexia, bulimia, other)  | <b>Yes/No</b> |
| Have you ever been admitted into hospital with a mental health problem?<br><i>Please give details if you have answered yes, with dates.</i>            | <b>Yes/No</b> |
| <b>Eyesight</b>  |               |
| Do you suffer from or ever had an eye disease or problems with vision?   | <b>Yes/No</b> |
| Do you wear glasses/contact lenses?<br><i>Please give details.</i>   | <b>Yes/No</b> |
| <b>Hearing</b>   |               |
| Do you have any degree of hearing impairment?<br><i>Please give details</i>  | <b>Yes/No</b> |
| Do you have any problems with reading and writing? (eg dyslexia)   | <b>Yes/No</b> |
| Are you pregnant? (We only need to know so we may help reduce any risks to you and the unborn child).  | <b>Yes/No</b> |
| <b>Severe Head Injury or organic brain problems</b>  |               |
| Do you suffer from significant memory, concentration or functional difficulties? <b>Yes/No</b><br><b>Please give details if you have answered yes.</b> |               |

|                           |
|---------------------------|
| <b>Employment History</b> |
|---------------------------|

Have you ever received any compensation for illness or injury? **Yes/No**

How many days absence from work have you had in the last two years?  
**Please give reasons and approximate length of time of each absence.**

Have you ever been medically retired from any job or left employment due to ill health? **Yes/No**

Have you ever required any adjustments to working hours, duties or work place due to ill health or related matters? **Yes/No**

Have you ever suffered from Chronic Fatigue Syndrome?  
If 'Yes' are you currently waiting for any medical treatment or tests? **Yes/No**

Have you been a night worker?  
If Yes have you suffered any ill health effects as a result? **Yes/No**

### **Immunisations**

Have you had chicken pox illness or shingles? **Yes/No**

*If no, you are at risk of contracting the disease and you should be aware that it could affect the unborn child in a pregnant lady who has not had the disease. Vaccination is recommended.*

Have you had rubella vaccination or illness? **Yes/No**

*If no, you are at risk of contracting the disease and you should be aware that it could affect the unborn child in a pregnant lady who has not had the vaccination or past history of the illness. Vaccination is recommended.*

Have you been vaccinated against TB? (BCG vaccination that leaves a scar, usually on upper left arm) **Yes/No**

*If no, you are at risk of contracting the disease. Vaccination is recommended.*

To your knowledge have you ever had Hepatitis B? **Yes/No**  
*Vaccination is recommended.*

**Working in the environment of challenging behaviour can be extremely physically and mentally demanding.**

**You should disclose now any condition which may cause you difficulty in carrying out your duties.**

I will respond honestly and fully to the pre-employment health questionnaire and give additional information on any health or disability problems that I may have. I acknowledge that concealment of information may be considered as an issue of contract.

Name  
Signed  
Date