NEW EMPLOYEE HEALTH QUESTIONNAIRE

EMPLOYEE DETAILS:

New Employee's Name:

New Employee's Job Title:

THE JOB CAN INCLUDE:

Significant Manual Handling	X	00:00–12:00hrs Night Working	X		

PERSONAL DETAILS: *TO BE COMPLETED IN BLOCK CAPITALS BY THE EMPLOYEE*

SURNAME:

Forename(s):

Date of Birth:

Home Address:

Postcode:

Gender:

Mr/Mrs/Miss/Ms

E-Mail:

Telephone No:

Mobile No:

Important information for the applicant

The contents of this questionnaire will remain confidential.

The purpose of new employee health questionnaire is to ensure that:

i. New staff do not have a health problem or disability that might impair their ability to carry out the tasks required in their new post

ii. The need for ongoing health surveillance can be identified

Applicants are advised that any false or misleading answers or failure to give pertinent information may render the individual liable to disciplinary action which may include dismissal.

iii. To make sure sure you are suited to work at night should you choose night shifts.

DECLARATION AND CONSENT: *TO BE COMPLETED BY THE EMPLOYEE*

I certify that the information I have given is true to the best of my knowledge. I agree to notify Staff 2000 of any change in my health which may affect my ability to undertake my job safely.

SIGNED:

DATE:

PRINTED NAME:

…… ……

Are you currently pregnant? Yes □ No □

(This information is required only to protect you under the New and Expectant Mothers at Work Regulations). *Please note it is important for your protection that you inform your Staff 2000 of your pregnancy as early as possible.*

Have you experienced difficulty with reading or written material e.g. dyslexia? Yes □ No □
Do you consider yourself to have a disability? Yes □ No □
If yes, please give details: ……

(This information is required only to protect you under the Disability Discrimination Act). The Act states that a "person has a disability for the purpose of this Act if they have a physical or mental impairment which has a substantial and long term adverse effect on their ability to carry out normal day-to-day activities".

Do you have any health condition which you consider could be made worse by working at night?
Yes □ No □

If YES, please give details:

(This information is required only to protect you under the Working Time Directive)

YOUR MEDICAL HISTORY

Have you ever suffered from any of the following? (Please tick YES or NO).

		Y	N			Y	N
1	Heart disease			21	Skin disease		
2	High blood pressure			22	Eye disease/visual problems		
3	Lung disease			23	Colour blindness		
4	Have you or any of your family suffered from TB?			24	Migraine/severe headaches		
5	Asthma/hayfever			25	Depression/anxiety		
6	Allergies e.g. latex			26	Other psychiatric illness		
7	Jaundice/hepatitis			27	Alcohol or drug problem		
8	Typhoid			28	Stress related illness		
9	Serious infectious disease			29	Serious Accident		
10	ME/Post viral fatigue syndrome			30	Other conditions		
11	Kidney/bladder disorder			31	Have you undergone any operation?		
12	Back pain			32	Have you contacted a doctor in the last 6 months?		
13	Joint or muscle pain			33	In the last year, have you had a cough for more than three weeks or coughed up blood?		
14	Ear/nose/throat disease			34	In the last year have you had any unexplained weight loss or night sweats or fevers?		
15	Fits/blackouts/faints			35	Are you at present taking medication?		
16	Menstrual/gynae problems			36	Are you waiting for any medical treatment or test?		
17	Indigestion/bowel disorder			37	Have you lost time from work or school due		
	Migraine/severe headaches				to illness in the past two years?		
18	Diabetes			38	Have you in the last five years been treated in hospital either as an in-patient, outpatient, day case?		
19	Cancer			39	Have you ever been retired on an ill-health pension?		
20	Hernia			40	Have you ever suffered from HAVS, Raynauds Disease or Carpal Tunnel Syndrome?		

If you have answered YES to any of the above, please give details and continue on a separate sheet if paper if necessary: