STRICTLY PRIVATE AND CONFIDENTIAL

UNITY
OCCUPATIONAL HEALTH AND WELLBEING

EMPLOYMENT QUESTIONNAIRE

Application for Employment:	**Job Description**					
	Company					
	Location					
Employment will involve (Please tick)	**DSE (computer) Work**		**Manual Handling**		**Repetitive Upper Limb Tasks**	
	Lone Working		**Food Handling**		**Night Worker**	
	Other Potential Risks e.g.: Ground Maintenance, etc					

This information is for medically confidential use only and will not be released to unauthorised persons. The purpose of this questionnaire is to assist your employer to meet the statutory duty to maintain a safe working environment for all employees and where necessary to meet any obligations under the Equality Act 2010.

The information regarding your past and present health state provided on this form will be used to:

- Assess your medical fitness or capability to do the job you have applied for
- Determine whether any reasonable adjustments may be required to accommodate any disability or impairment you may have
- Ensure that none of the requirements of the job for which you have applied would adversely affect any pre-existing health conditions you may have

Completed questionnaires that are returned to the Human Resources Department may be read, the original kept and copied, prior to forwarding it to Unity Occupational Health & Wellbeing for review of your responses on the form.

Please read the questions carefully and answer them accurately and honestly as it is your responsibility to inform Occupational Health and your Employer of any health issue which could be affected by the work or affect your ability to do the work.

Surname		First Name			
Title/Prefix		Date of Birth		Telephone No.	
Address					
			Postcode		
Email					

Give details of previous employment for the last ten years:

Previous Employer	Occupation/Type of Work	Length of service and reason for leaving

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PLEASE TICK APPROPRIATE ANSWER

General Health

		Yes	No
1.	Can you perform the essential functions of your job with or without reasonable accommodation?	○	○
2.	Do you need any changes to be made in the workplace?	○	○
3.	Do you have any developmental or learning disorder such as autism, ADHD, dyslexia, dyspraxia or Tourette's Syndrome?	○	○
4.	Do you have any health concern or any condition that may impact on your ability to undertake your job, that should be considered under the scope of neurodiversity?	○	○
	If you have answered YES to any of the above questions, please give details in this information box		
5.	Are you currently suffering from any form of ill health?	○	○
6.	Do you have any disabilities that affect your ability to work?	○	○
7.	Do you have any medical limitations affecting your ability to work?	○	○
8.	Do you need any special aids, adaptations or adjustments required to help you in your job?	○	○
	If you have answered YES to any of the above questions, please give details in this information box		
9.	Do you have or have you ever had any health problems or medical conditions which may have been caused or made worse by work, for example: Work Related Upper Limb Disorder, Hand/Arm vibration Syndrome, Skin or Respiratory Conditions etc.?	○	○
10.	In your past or present employment have you been exposed to any workplace hazards e.g.: Noise, Dust, Chemicals, etc?	○	○
11.	Do you have any difficulty standing/walking/lifting/climbing stairs?	○	○
12.	Are you currently receiving or waiting for, any treatment or follow up, for any emotional or physical health condition?	○	○
13.	Is there any reason why you could not wear personal protective equipment?	○	○
14.	Have you ever been refused employment on medical grounds?	○	○
15.	Have you ever had a period of extended leave or given up a job for medical or ill health reasons?	○	○
	If you have answered YES to any of the above questions, please give details in this information box		

12.	Please give your	Height:	Weight:	
13.	Do you smoke? ○Yes ○No	How many cigarettes/grams of tobacco do you smoke per day?		
	If stopped – When?		How long have you smoked for/did you smoke for?	
14.	Alcohol – how many drinks/units do you have in an average week? (One drink/unit = half pint of beer, small glass of wine, or a single short)			
15.	Sports & hobbies (please indicate your activities and interests)			

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Present Medical History

Please answer the following questions by ticking the appropriate YES/NO box. If the answer is yes, please give details.
Have you ever had - in your life, including childhood, any of the following?

	Description of Illness	Yes	No
1.	Impaired vision/eye problem/ difficulty being able to read clearly with or without glasses.	○	○
2.	Nose and throat problems, or infections or sinusitis.	○	○
3.	Ear problems or difficulties in hearing.	○	○
4.	Allergies and/or hay fever.	○	○
5	Asthma or lung condition.	○	○
6.	Skin problems e.g., psoriasis, eczema, dermatitis	○	○
If you have answered YES to any of the above questions, please give details including dates and treatment received in this information box			
7.	High blood pressure	○	○
8.	Heart or circulation condition, including chest pains, angina, heart attack.	○	○
9.	Stroke	○	○
10.	Blackouts, epileptic fits, fainting, periods of unconsciousness or neurological disorder.	○	○
11.	Frequent or severe headaches/migraines.	○	○
12.	Vertigo or episodes of disabling dizziness.	○	○
13.	Nervous disorder/breakdown, depression or anxiety, any mental condition requiring treatment. Suffered Stress (work or non-work related)	○	○
14.	Sleep apnoea or other sleep disorders.	○	○
If you have answered YES to any of the above questions, please give details including dates and treatment received in this information box			
15.	Diabetes. If YES, are you on insulin?	○	○
16.	Recurrent indigestion, gastric or duodenal ulcer.	○	○
17.	Intestinal disorder including recurrent or persistent diarrhoea or colitis.	○	○
18.	Tumour or cancer.	○	○
19.	Gynaecological problems (FEMALES ONLY)	○	○
If you have answered YES to any of the above questions, please give details including dates and treatment received in this information box			
20.	Severe back pain/sciatica, prolonged or recurring, or causing absence away from work for two or more weeks.	○	○
21.	Neck or shoulder pain/problems - prolonged or recurring	○	○
22.	Joint or associated problems: (arms or legs) Painful or persistently aching limbs e.g.: arthritis, tenosynovitis, tennis elbow, frozen shoulder, etc., or have restricted mobility of your limbs.	○	○
23.	Broken bones/ fractures (which ones) or bone disease	○	○
24.	Problems standing, swollen ankles or varicose veins	○	○
If you have answered YES to any of the above questions, please give details including dates and treatment received in this information box			

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	Description of Illness	Yes	No
25.	Have you ever had any major operations, accidents, injuries or hospital admissions resulting in significant restrictions or disabilities?	○	○
26.	Have you been treated for any other condition not so far mentioned?	○	○
27.	Are you currently taking any tablets, pills or medicines, including prescription and non-prescription drugs?	○	○
28.	Have you had time off work due to sickness in the past 2 years? If YES, how many times? How many days? Please give reason/s	○	○
29.	Do you use illegal or recreational drugs?	○	○
39.	Have you ever been treated for excessive use of alcohol or drug abuse?	○	○
31.	Is there any other health related information you believe Occupational Health should know about?	○	○

If you have answered YES to any of the above questions, please give details including dates and treatment received in this information box:

Should there be any answers given in the above sections, or findings in your examination, which necessitate further enquiry, it may be necessary for the Occupational Health Advisor to contact your General Practitioner or Specialist for a medical report. This will be in compliance with the Access to Medical Records Act 1998 and with your written consent.

Declaration

I understand that all information from this questionnaire and associated clinical examination will be treated with confidence. I accept that a report regarding my fitness for employment, based on this information will be made to my prospective employer.

I understand that I may be asked to authorise my Doctor or Specialist to supply a report concerning my health if required by the Occupational Health Department for which a consent form will be provided and explained in accordance with the Access to Medical Reports Form to Medical Records Act 1998.

I certify that the information given by me in this questionnaire is, to the best of my knowledge and belief, true and correct. I understand that false or misleading statements or failure to make a full declaration of health may prejudice my continued employment or lead to termination of employment on discovery.

Name (Capitals) _____Signed:_____Date:_____

For Occupational Health Department Use only:

Signature		Name		Date	
Recommendations					

SEQOHS

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