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| --- | --- |
| **Job Title** |  |
| Division |  | Location |  |
| Start Date |  | Part Time ⬜  | Full Time ⬜ |
| The Job Involves |   |
| ⬜ Earthmoving machinery operation | ⬜ Survey Work |
| ⬜ Regular manual handling/lifting duties | ⬜ Office Work |
| ⬜ Regular truck driving duties | ⬜ Regular VDU usage |
| ⬜ Construction site work/labouring | ⬜ Other hazards (please state) |

**Please read the following before completing the questionnaire**

* The company will retain the questionnaire. It will be used to assess whether there are any health issues relevant to the proposed work. Further assessments may be needed and you may be required to attend for regular health surveillance during employment. Detailed clinical information will not be revealed without your consent.
* If further information is required for your GP or Specialist this will only be obtained with your written consent.
* In signing this questionnaire you confirm that all information provided is true to the best of your knowledge. You also accept that in the event of being employed, if it is subsequently shown that medical information has not been disclosed by you, or has been misleading or false, then you become liable to disciplinary proceedings that may include dismissal.

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| **Personal Details** |
| **Surname** |  | **Mr/Miss/Mrs/Ms** | **Date of Birth** |  |
| **Forenames** |  | **Maiden/Previous Name** |  |
| **Address** |  |
|  |  |
| **Contact Details** | **Home** |  | **Mobile** |  |
| **Work** |  | **email** |  |

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| **WORK RELATED HEALTH HISTORY** |  |  | **If YES, give details and dates** |
| a. Have you been absent from work or full time study due to ill health during the last 12 months (including illness such as colds etc)?  | Yes | No | If Yes, include number of days and reason |
| b. Have you ever left, or been denied a job on health grounds? | Yes | No |  |
| c. Have you ever been denied a driving license on health grounds? | Yes | No |  |
| d. Have you ever suffered from any work- related health conditions? | Yes | No |  |
| e. Have you ever had an accidental sharps injury or exposure to blood/bodily fluids with broken skin or mucous membranes? IF Yes include opposite* Date of accident
* Status of source if known
* Details of treatment given at time of injury
* Details of follow up blood test results/surveillance
 | Yes | No |  |
| **HEALTH HISTORY** |  |  | If YES, give details and dates |
| **a. Conditions of the lungs**Asthma? Bronchitis? Pleurisy? Tuberculosis? Other chest complaints? Coughing up blood? Shortness of breath? Any other conditions?  | Yes | No |  |
| **b. Conditions of the heart?**High blood pressure? Heart attacks? Angina?  | Yes | No |  |
| **c. Nervous system disorder?**Blackouts? Epilepsy? Muscular weakness? Paralysis? | Yes | No |  |
| **d. Migraine or persistent headaches?** | Yes | No |  |
| **e. Conditions of digestive system?**Irritable bowel syndrome?Liver complaints/jaundice?Colitis? Gastric/duodenal ulcer? | Yes | No |  |
| **f. Conditions of kidney or bladder?**Urinary infection? Kidney stone? | Yes | No |  |
| **g. Conditions of bones, joints, and limbs?**Arthritis? Rheumatism? Back problems? Neck or shoulder problems? Sciatica? Upper limb disorder? Tennis elbow? Any other conditions?  | Yes | No |  |
| **h. Allergies?**(including allergies to drugs, dust, animals and pollen?) | Yes | No |  |
| **i. Skin conditions?**Eczema? Dermatitis? Psoriasis? Recent infection? Skin Cancer? | Yes | No |  |
| **j. Gland trouble?**Diabetes? Thyroid overactive/underactive? | Yes | No |  |
| **k. Eye conditions?**Restricted vision? Glaucoma? Iritis? Any other condition? | Yes | No |  |
| **l. Ear conditions?**Restricted hearing? Tinnitus? Ear Infection? | Yes | No |  |
| **m. Alcohol or drug problem?**Problems related to alcohol or drug usage or dependency? | Yes | No |  |
| **n. Mental illness and/or stress related problems?**Nervous breakdown? Mental fatigue? Anxiety? Depression? Panic attacks? Significant sleep disturbance? Stress related problems? Eating disorders? Self harm? Any other conditions?  | Yes | No |  |
| **o. Have you consulted a specialist or needed any operation other than already stated?**  | Yes | No |  |
| **p. Have you spent any time in hospital other than already stated?** | Yes | No |  |
| **q. Have you consulted your GP in the last 12 months?** | Yes | No |  |
| **r. Are you receiving medical treatment at the present?** | Yes | No |  |
| **s. Do you take regular medication?** | Yes | No |  |
| **t. Are you aware of having any disability that is covered by ACC?** | Yes | No |  |
| **u. Have you any disabilities affecting sight, hearing, standing, sitting, walking, lifting, driving, stair climbing, use of the hands or ability to carry out any work indicated in the first section?** | Yes | No |  |
| **v. Have you any other health issues that have not been mentioned above or about which you would like to provide further details?** | Yes | No |  |

Thank you for completing this questionnaire. Please check that you have given all the information required and than complete the declaration.

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| **DECLARATION** |
| 1. I declare that all the foregoing statements are true to the best of my knowledge.
2. I understand and accept that I may be required to attend for a health assessment and/or undergo a medical examination
3. I understand and accept that further medical information may be requested from my doctor if considered necessary.
4. Under the Provisions of the Privacy Act, I authorize the Company to seek further verbal or written information in support of my application. I understand that all such information is supplied in confidence and will be kept confidential and will not be disclosed to any other party without my written permission.
 |
| **Name (BLOCK CAPITALS)** |
| **Signature:** | **Date** |