Health Questionnaire

An answer must be provided for all questions. The information will be treated **in confidence.**

PLEASE COMPLETE IN CAPITAL LETTERS

Title	Surname	First Name	DOB

Home Tel:	Work Tel:	Mobile:

Home Address:	GP Name: GP Address: GP Tel:

MEDICAL HISTORY

Please complete the following questions by ticking the appropriate box. If the answer is 'yes', give details including (a) date, (b) amount of time lost from work/school, (c) treatment, as appropriate.

Have you ever suffered from any of the following illnesses?	**Yes**	**No**	**Please provide details**
Visual defects/eye conditions (including colour-blindness)			
Hearing defects/ear conditions			
Severe anxiety, depression, other psychiatric disorder			
Paralysis or other neurological disorder			
Fainting attacks, blackouts, epilepsy or fits			
Recurrent headaches, migraine			
Vertigo, giddiness or tinnitus			
Heart disease, high blood pressure			
Asthma, bronchitis, tuberculosis or other chest disease			
Peptic ulcer or other digestive or bowel disorder			
Liver disorder			
Kidney of bladder problems			
Gynaecological problems			
Recurrent backache, arthritis, rheumatism			
Any blood disorder			
Eczema, dermatitis, other skin conditions			
Diabetes, thyroid or other gland problems			
Hayfever, allergies to drugs, animals etc			
Any recurrent infections			

Any impairment of immunity to infection			
Varicose veins causing trouble			
Hernia			
Any alcohol or drug related problems or illness			
Any other medical condition, physical or mental, not mentioned above			

HAVE YOU EVER

Ever undergone a surgical operation or been admitted to hospital for any reason?			
Had more than 20 days sickness absence in the past 2 years?			
Ever been, or are a Registered Disabled Person?			
Received a Disability Pension?			
Suffered from an Industrial Disease/Accident?			
Had a chest X-ray in the past 12 months – If so state place / date / result			

PRESENT HEALTH STATUS

Are you currently attending a doctor?			
Are you at present on any medication or treatment prescribed by a doctor?			
Are you a smoker? If so please give details			
Do you drink alcohol? If so how many units per week? (NB 1 unit is ½ pint of beer or 1 medium glass of wine)			
Do you have any eyesight defects other than those corrected by glasses?			
Do you have any hearing problems?			
Do you have any defect of speech or communication problem?			
Do you have any physical disability necessitating special aids, or requirements for access to premises?			
Do you have any physical disability necessitating special aids, or requirements for access to premises?			
Do you have any other relevant health problems?			

Declaration

1) I declare that, to the best of my knowledge, the information I have given is correct.
2) I understand that I may be required to attend a medical examination
3) I understand that failure to disclose relevant information or giving false information may result in termination of my employment.
4) I understand that Zippy Care (sister company of Last Minute Care & Nursing) operate as an Equal Opportunity Employer

Signature …….. **Date** ……