



E.3.2

**FITNESS FOR EMPLOYMENT
MEDICAL QUESTIONNAIRE**

STRICTLY PRIVATE AND CONFIDENTIAL

Completed form to be returned by shortlisted applicant in a sealed envelope on the day of interview

Name in full: Title.....

Maiden or previous Surname(s).....

Date of birth..... Age.....

Address.....

.....

.....

Telephone No

Proposed appointment.....

MEDICAL INFORMATION

Height without shoes..... Weight in indoor clothing.....

If you have suffered from any of the following, write 'YES' in column (i) and give the date in column (ii). If the answer is 'NO' please write 'NO' in column (i) opposite each item.

EVERY QUESTION MUST BE ANSWERED 'YES' OR 'NO'.

		(i) Yes/No	(ii) dd/mm/yy
1	Tuberculosis of the lung or other part of the body		
2	Asthma or hay fever or other allergic conditions(including allergies to animals etc).		
3	Any other disease of the lung e.g. Pleurisy, bronchitis, pneumonia		
4	Rheumatism or arthritis		
5	Heart disease		
6	Disease of the nervous system		
7	Epilepsy, convulsions, blackouts, attacks of fainting or dizziness		
8	Any form of mental illness or nervous breakdown		
9	Hernia		
10	Back trouble or back injury		
11	Any other disabling condition or disabling incapacity		
12	Typhoid or paratyphoid, glandular illnesses		
13	Dysentery		
14	Other significant ailments of stomach, bowels or digestive system		
15	Any disease of kidneys or bladder or liver or reproductive organs		
16	High blood pressure		
17	Skin diseases, skin rashes and allergies		
18	Frequent sore throats, tonsillitis, ear infections		
19	Diabetes		
20	Blood disorders, ie pernicious or other severe anaemia		
21	Migraine, headaches		
22	Varicose veins		
23	Tropical diseases ie, Malaria, Legionnaires disease		

(See also Question c below)

QUESTION	YOUR RESPONSE
a If there is an answer 'YES' to any of the previous questions, please provide further details, e.g. duration of illness, nature of treatment, nature of allergy, date of return to work, any further attack etc	
b Are there any defects in your sight or hearing? If so, give details and state whether it has been corrected, e.g. by glasses or hearing aid?	
c Have you ever had any serious accident or operation or suffered from any severe illness not listed? Please specify and give dates	
d Are you currently taking medication (other than for contraceptive purposes)? If so - (i) What (ii) For what purpose	
e Do you ordinarily enjoy good health?	
f Have you during the last five years had any absences from work because of illness (including injury or other disability) totalling ten days or more in any one year? If so give particulars	
g Have you ever had a chest X-ray (including mass radiography)? If so: (i) for what reason? (ii) when (month, year)? (iii) where? (iv) with what result?	
h Do you have a disability? If so, please state disability	
i Have you any reason to believe you would be refused entry to a sickness / pension fund or refused life assurance?	
j Have you left any previous occupation or been rejected on any application for employment on medical grounds?	
k Please give the name, address and telephone number of your own General Practitioner.	
l And the name of any consultant who has treated you during the past three years	

m Have you been immunised against the following?				
	Yes	No	Date	Booster Date
Diphtheria				
Whooping Cough				
Poliomyelitis				
Rubella (German Measles)				
Tetanus				
Typhoid				
Hepatitis B				
Hepatitis B blood test				Titre Level
TB				
Do you have a BCG vaccine scar?				
Have you had a heaf test?				

DECLARATION

I declare that I have answered the above questions honestly and fully and that I am not otherwise aware of any physical or mental disability which will, or may, affect my working capacity. I realise that, if appointed, any false or incomplete statement on my part will render me liable to dismissal. I agree to make myself available for a medical examination by a suitably qualified practitioner at CROSSROADS expense if it is felt details disclosed in the document warrant further investigation in the light of the vacancy for which I am being considered. I agree that a report on my fitness for employment be made to the appropriate Manager.

If it is necessary for CROSSROADS Caring for Carers to communicate with my own Doctor and/or consultant who has treated me, I authorise them to reply to any query concerning my health or medical history. Likewise, I agree to my doctor being informed of the results of any tests taken, which CROSSROADS considers should be brought to my doctor's attention.

If it is discovered that I have an illness or disability, the details of which should be made known to my potential employer in confidence for my own safety or that of other members of the staff or clients I authorise the examining medical officer to disclose to my potential employers such details as he/she may consider necessary.

SIGNATURE **DATE**

Please return this form to Crossroads Caring for Carers in a sealed envelope.