Employee Health Questionnaire

About this form

We are required by law to assess your physical and mental capability do your job safely and effectively and, where necessary, to make reasonable adjustments to accommodate any disability you may have. Doing this means you and others can be better protected.

Please complete the form honestly and accurately and ask for help if you need it. In line with the Data Protection Act, the information you enter in this form will be confidential and will not be revealed to anyone else without your written consent.

Part A – Your Personal Details

First Name		**Surname**	
Date of Birth		**Phone**	
GP Name			
GP Address			

Part B – Your Emergency Contact

Name		**Relation to You**	
Phone			

Part C – Your Job Role

Job Title			
Contract Type	Zero Hours ☐	Part-Time ☒	Full-Time ☐
Do you have a single place of work			
If 'Yes', please give location			

Part D – Other Employment

Please give details of any other employment you have:

Job Title

Employer's Name

Phone

Contract Type **Zero Hours ☐** **Part-Time ☐** **Full-Time ☐**

Do you have a single place of work? **Yes ☐** **No ☐**

If 'Yes', please give location

Part E - Information Regarding Your Proposed Job Role:

	Please Write YES or NO	If appropriate, please give further details.
Will you be frequently (more than an hour a day) use display screen equipment including laptops?		
Will your role include manual handling (restraint etc.) with a possibility of injury?		
Will your role include driving a passenger carrying vehicle?		
Will you potentially come in contact with other peoples blood, urine, faeces or saliva?		
If yes to the above question, have you had Hepatitis B injections and if so, when?		
Have you had your COVID Vaccinations, please give dates.		

Please complete the following:

Height ft/ins _____ or metres _____	**Weight** st/lbs _____ or kilos _____

Have you ever had:	**Please write YES or NO**	**If appropriate please give further details including which condition you suffer from**
1. Any problems with your eyes / eyesight (if you wear glasses please give details).		
2. Problems recognizing colours?		
3. Or are you at present under medical treatment (including the taking of regular medication), observation or investigation?		
4. Diagnosis of dyslexia or do you believe you could be dyslexic?		
5. Regular migraine or severe headaches.		
6. Any fits or epilepsy, giddiness, fainting or blackouts.		
7. High blood pressure, anaemia, blood disorders or heart problems.		
8. Hepatitis B?		
9. Mental or nervous disorders, including stress, anxiety, depression, emotional problems.		
10. Asthma, recurrent bronchitis, tuberculosis, pneumonia or breathing difficulties.		
11. Recurrent or persistent indigestion including gastric or duodenal ulcers.		
12. Colitis, recurrent bowel disorder, jaundice, liver disease or gall stones.		
13. Kidney, bladder or other urinary disorder.		

Have you ever had:-	Please write YES or NO	1. If appropriate please give further details including which condition you suffer from
14. Backache, lumbago, sciatica, slipped disc or any other Musculo-skeletal problems, including wrist or foot problems.		
15. Do you have any known allergies including food allergies?		
16. Any skin disorders e.g. dermatitis, eczema, psoriasis or warts.		
17. Any ear/nose/throat disorders including discharge from ears, tinnitus or deafness.		
18. Diabetes or thyroid gland disorder		
19. Any breast/gynaecological or menstrual (females) or testicular or prostate problems (males)?.		
20. Any drug or alcohol related problems.		
21. Have you been referred to occupational health with a health problem that might recur?		
22. Are you suffering from any physical or mental disorders not already mentioned?		

* 1 unit – ½ pint beer or cider / 1 glass of wine / 1 pub measure of spirits.

	Please write YES or NO		
23. Are you likely to undertake lone working i.e. being alone within a department for more than an hour?		If 'YES' Please provide details:	
24. Do you smoke.		If 'YES' what and how many.	
25. Do you drink alcohol.		If 'YES' how many units per week or give actual amount and type of drink per week.	

26. Do you use illegal drugs?		If 'YES' what, how frequently and how much.	
27. Have you ever had any illness, medical problem or disability that may affect your ability to work r?		If 'YES' Please describe.	
28. Have you ever been treated in hospital?		If 'YES' Please provide reason(s) and dates.	
29. Have you seen a doctor in the last year for ***any*** kind of health problem?		If 'YES' Please provide reasons	
30. Have you had COVID		If 'YES' Please provide details	
31. If you have had COVID do you have any long lasting issues related to this		If 'YES' Please provide details	
32. Have you had any illness or health related problem that may have been caused or made worse by your work?		If 'YES' Please provide details	
33. Have you medically retired from ***any*** job because of ill health?		If 'YES' Please provide details	
34. Do you have any difficulties standing, bending, lifting or with any other movements?		If 'YES' Please provide details	
35. Have you ever had any problem with your joints including pain, swelling or stiffness?		If 'YES' Please provide details	

Part N – Declaration

Note: With your written consent, we may contact your GP to confirm that you are able to undertake your job role without risk to your health, safety and welfare.

I declare that the information I have provided in this form are true and complete to the best of my knowledge and belief. I understand and agree that if I have knowingly made any false statements in this form, this may constitute a breach of my contract of employment.

Signed _____ **Date** _____

Office Use Only

Form reviewed by:

Name		**Job Title**	
Signed		**Date**	

The form must be evaluated with reference to the Employee Health Questionnaire Guidance. Make any additional notes or comments here: