

## PRE – EMPLOYMENT MEDICAL QUESTIONNAIRE

Full Name:	
Address and Postcode	
Contact Tel No:	
GP Name and address	

All questions must be answered. **Do not leave blank spaces.** If in doubt and you wish to consult your GP/Medical Adviser please advise us before completing this form. We will not contact your doctor without your prior written consent. In all cases please contact on a separate sheet if necessary.

How many days' absence have you had from work in the last three years?	days								
How many occasions of absence from work have you had in the last three years?	days								
Have you had any periods of absence from work due to sickness for more than two weeks in the last two years, if yes please give details.	YES/NO								
Are you currently on medication (excluding contraceptives) or receiving medical treatment?  If YES, please give further details.	YES/NO								
Have you ever been considered medically unfit for any previous employment, life insurance policy, HM Forces or a driving licence or retired from a post due to ill health?	YES / NO								
Have you spent time in hospital in the last three years? If yes, why?	YES/NO								
Are you <b>at present</b> suffering from, <b>or</b> have suffered <b>in the last 5 years</b> from, any of the following? Please circle if yes and give dates on a separate sheet									
Defective vision (not corrected by glasses/contact lenses) Chest disease/pain	<table border="1"> <tr> <td>Cancer</td> <td>Epilepsy</td> </tr> <tr> <td>Leukaemia</td> <td>Back strain/trouble/pain</td> </tr> <tr> <td>Head injury/Concussion/ Giddiness</td> <td>Hernia rupture</td> </tr> <tr> <td></td> <td>Diabetes</td> </tr> </table>	Cancer	Epilepsy	Leukaemia	Back strain/trouble/pain	Head injury/Concussion/ Giddiness	Hernia rupture		Diabetes
Cancer	Epilepsy								
Leukaemia	Back strain/trouble/pain								
Head injury/Concussion/ Giddiness	Hernia rupture								
	Diabetes								

Persistent cough / spitting blood	Arthritis/knee or hip replacement	High blood pressure
Varicose veins	Fear of enclosed/open spaces	Anxiety or depression, schizophrenia
Recurring headaches or migraines	Serious illness/operation	Rheumatic fever
Heart disease	Serious injury/accident	Drug/alcohol problems/dependence
Stress	Severe hay fever or any other allergy	Stroke
Mental/nervous illness	Colour blindness	Epilepsy
Kidney disease	Thrombosis/leg/foot problems	Ear trouble/deafness
Typhoid / Dysentery	Recurring stomach/bowel trouble/Irritable Bowel Syndrome	Any other significant infection
Skin trouble/rash/dermatitis/eczema/psoriasis or any other skin condition	Tuberculosis	Hospital admission
Bronchitis/Emphysema	Recurring bladder trouble	
Muscle or joint trouble	Asthma	
Fits/blackouts/fainting attacks	Pneumonia/Pleurisy	
Do you suffer from any injury, illness, medical condition or allergy that might affect your ability to perform your duties?  If YES, please give further details.	YES/NO	
Are you registered disabled or do you have any disability which you consider would impact on the job for which you are applying?	YES/NO	
Please indicate if you have any disabilities which affect:	Standing YES/NO Manual handling YES/NO Walking YES/NO Use of your hands YES/NO Bending/stretching YES/NO Climbing stairs YES/NO Lone working YES/NO	
Do you consider yourself to have a disability? If yes, please give further details.	YES/NO	
Have you ever had to change jobs or works assignments because of a health problem or injury? If yes please give details.	YES/NO	
Have certain types of work caused you significant strain in your limbs or back? If yes please give details.	YES/NO	
Do you expect to ask for leave of absence on medical grounds in the near future (next 6 months)? If yes please give details.	YES/NO	
Do you smoke?	YES/NO	

Data Protection Notice:

The New Pathways Group requires certain information prior to you commencing employment, to ensure you will be able to perform the requirements of the job and give reliable service, and to ensure compliance with relevant Health and Safety regulations. The information is also required in order to establish whether any reasonable adjustments may need to be made to assist you in performing your duties, in accordance with the Disability Discrimination Act 1995.

The information you provide will be treated in the strictest confidence, and used only for the purposes detailed above in compliance with the Data Protection Act 1998.

I hereby declare that all the above answers are, to the best of my belief, true and complete and I have not withheld any information, which would help in determining my medical fitness for the post for which I am being considered. I understand that declaring the information above will not automatically deem my application unsuccessful however the information disclosed must be to the satisfaction of the directors.

I understand that it will be a condition of my employment with Inspire that a **failure to disclose any material information could lead to my appointment being terminated.**

If it is necessary to obtain a medical report from your GP or other medical adviser you will be notified by letter. In such cases, your rights under the Access to Medical Reports Act 1988 will be explained to you. The same rights would also apply if, at any time in the employment of New Pathways Group medical advice were sought about your fitness for work.

Signature:	Date:
Name:	

Thank you for completing this form.