

The Manor House, Squires Hill, Rothwell, Northants, NN14 6BQ
Tel: 01536 711111 Fax: 01536 712994

EMPLOYERS MEDICHECK QUESTIONNAIRE

Full Name:	Proposed Job/Position to be filled:
Address:
.....
.....
Date joining Company:
Name & Address of your Doctor:	
.....	
.....	
Date of last visit:
Reasons for visit:	Date of Birth:

MEDICAL INFORMATION:	
Have you at any time suffered from or had any symptoms of the following complaints:	
(a) Depression, anxiety state, nervous illness or breakdown.	YES/NO
(b) General debility arising from over work or from any other cause.	YES/NO
(c) Fainting attacks, fits or any disease of the nervous system, e.g. epilepsy.	YES/NO
(d) Persistent cough, asthma, pleurisy, bronchitis or any other ailment of the lungs or chest.	YES/NO
(e) Rheumatism, arthritis, gout, backache, 'disc' trouble, rheumatic fever, joint or tendon disorder e.g. tenosynovitis or repetitive strain injury.	YES/NO
(f) Palpitations, shortness of breath, chest pains, raised blood pressure or other ailment of the heart or circulatory system.	YES/NO
(g) Indigestion, diarrhoea, gastric or duodenal ulcer, gall stones, or any other ailment of the stomach, intestines or liver.	YES/NO
(h) Any ailment affecting the kidneys or bladder.	YES/NO
(i) Diabetes, anaemia or any blood or gland condition.	YES/NO

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|-----|--|--------|
| (j) | Aliment affecting the eyes (indicate if colour blind). | YES/NO |
| (k) | Ailment affecting the ears. | YES/NO |
| (l) | Ailment affecting the nose or throat e.g. hay fever. | YES/NO |
| (m) | Varicose veins, rupture or piles. | YES/NO |
| (n) | Any injury, operation of physical abnormality. | YES/NO |
| (o) | Skin disorder e.g. Eczema, contact dermatitis. | YES/NO |
| (p) | Any illness not mentioned above | YES/NO |

IF ANSWER IS 'YES' GIVE FILL DETAILS OF DATES, SEVERITY AND TREATMENT
OVERLEAF

Have you ever had any special medical investigation, X-ray, cardiogram or blood or urine test. If 'yes' give details and results. YES/NO

Are you now, or have you recently been taking tablets, medicine, or drugs. If so, what for. YES/NO

What is your average weekly unit consumption of alcohol

(1 unit = ½ pint of beer *or*
1 glass of table wine *or*
1 glass of sherry *or*
a single measure of spirits)

Has it ever exceeded the present level YES/NO

Do you smoke YES/NO

If 'yes' could you refrain from doing so during working hours. YES/NO

Indicate the average quantity smoked in a week.

Have you ever smoked YES/NO

If ex-smoker when did you stop

Have you ever had any illness or disease involving treatment with Cortisone or other steroids. Please give name of drug and amount of daily dosage if the answers is 'yes'. YES/NO

Are you a registered disabled person (if so, please give registration number and nature of disablement) YES/NO

Do you need any special aids/adaptations YES/NO

PLEASE ALSO PROVIDE THE FOLLOWING INFORMATION:

The number of days/periods you have been sick during the last 12 months:

The number of days you have been sick in the last 8 weeks

Nature of illness

Do you expect to ask for leave of absence for medical reasons during the next 12 months

Details of any industrial disablement benefit received

Are you allergic to Penicillin, Tetanus or any other medication

ANY ADDITIONAL MEDICAL INFORMATION:

PLEASE READ CAREFULLY BEFORE SIGNING

1. I declare the above answers to be true and correct in every respect.
2. I understand and accept that if any of the information given by me in this questionnaire is incorrect or untrue, that the Company have the right to terminate my employment summarily.
3. Although I understand that I have the right to refuse, I hereby give my permission for the Company/Company Doctor to approach my own medical practitioner for further and better particulars of my medical history/records should the Company/Company Doctor so decide and for the submission of these facts/medical report to the Company.
4. I understand that should the above prove necessary, I have the following rights:
 - (a) To have access to the report prior to it being supplied to the Company.
I understand that I may be charged if I request a copy.
I do/do not* wish to exercise this right. (*Please delete as appropriate)
I understand that if I choose not to exercise this right, I have the right to have access to the report at any time during the six months following its issue.
 - (b) If I exercise my rights under 4 (a) above and do not respond to my Doctor within 21 days of the application for the report, I understand that the report will be forwarded to the Company.
 - (c) That within the 21 days referred to in 4(b) above I may request my Doctor in writing to amend any part of the report which I consider to be misleading or incorrect and if the Doctor is not prepared to do so, that a statement of my views is attached to the report prior to it being sent to the Company.
5. I am prepared to undergo a full medical examination at the Company's request if this is required

Signed:

Date:

For Medical Analysis and Comment

1 2 3 4

Category

Signed by Medical Assessor:

Date: