**EASTDALE HEALTHCARE**

**Health Questionnaire**

Please complete this form and return it with your offer of employment.

Thank you for completing this questionnaire. We have a duty of care to ensure that we are aware of any workplace adjustments we may need to make to reduce any risks to you in your place of work to avoid any further injury.

|  |
| --- |
| Name: Position: Support Worker |

|  |
| --- |
| Name and address of personal doctor: ………………………………………………………………………………..……….………......................................................................................................................................... |

|  |  |  |  |
| --- | --- | --- | --- |
| Giddiness, fainting attacks, epilepsy | **YES/ NO** | Stroke, heart trouble, high blood pressure or varicose veins | **YES/ NO** |
| Mental illness, anxiety or depression | **YES/ NO** | Diabetes | **YES/ NO** |
| Recurring headaches | **YES/ NO** | Skin trouble | **YES/ NO** |
| Serious illness, injury or operations | **YES/ NO** | Ear trouble or deafness | **YES/ NO** |
| Serious hay fever, asthma or recurring chest infections | **YES/ NO** | Colour vision or eye trouble not corrected by glasses or contact lenses | **YES/ NO** |
| Recurring stomach or bowel trouble | **YES/ NO** | Back or neck trouble or muscle/joint trouble | **YES/ NO** |
| Recurring bladder trouble | **YES/ NO** | Hernia or rupture | **YES/ NO** |

|  |  |
| --- | --- |
| Have you stayed away from work in the last year for longer than 2 weeks?**YES / NO** | *(If YES, why and for how long?)* |
| Have you ever changed your job for health reasons?**YES / NO** | *(If YES, please give full details)* |
| Please confirm the date of your last Tetanus injection | *Date* |
| Do you have any disabilities that affect the following:* Standing
* Walking
* Climbing stairs
* Lifting
* Using your hands
 | ***YES/NO*** *If Yes please give full details* |

|  |
| --- |
| **Declaration:** I declare that the information I have given on this form is true to the best of my knowledge and belief. I understand that a failure to provide information and/or a submission of inaccurate information relating to my health may result in breach of contract and disciplinary action being taken which would lead to dismissal.I am willing to undergo a medical examination if necessary.Signed: …………………………………. Date: ……………………………………. |

If you have answered ‘Yes’ to any of the question please give a brief explanation below:-