

## Pre-employment Medical Questionnaire

Position applied for  Department

Please complete this Questionnaire fully and to the best of your knowledge. If you are uncertain whether any information should be included or otherwise require assistance please ask. The information you provide will be treated as **STRICTLY PRIVATE AND CONFIDENTIAL**.

### 1. Applicant details

Surname  Forename(s)   
 Date of birth  Phone number   
 Home address

### 2. Personal information

Height  Weight   
 Weekly alcohol intake  Do you smoke? Yes  No   
 Do you use recreational drugs? Yes  No  Do you exercise? Yes  No   
 Are you currently any taking prescribed medication? Yes  No   
 Are you currently under the care of a health care professional? Yes  No   
 Are you registered disabled? Yes  No   
 General practitioner  GP's phone number   
 GP's address

### 3. Medical history

Do you presently suffer or have you in the past suffered any illnesses, injuries, conditions or problems involving or affecting any of the following:

Circulatory system	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Blood	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Respiratory system	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Dizziness/fits/fainting	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Headaches/migraines	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Epilepsy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	High blood pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Eyesight	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Hearing	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Back/neck	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Bones/joints/muscles	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Arthritis/rheumatism	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Mobility	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hernia/rupture	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Stomach	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Kidneys/liver	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Bowel/bladder	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Skin	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Allergies	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Depression/anxiety	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Severe stress reaction	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Alcoholism/addiction	Yes <input type="checkbox"/>	No <input type="checkbox"/>



## 6. Access to medical reports

*In order to clarify the information you have provided we may need to request a report from your doctor. The content of any such report will be treated as strictly private and confidential and used only for the purposes of your employment application. In such cases, the Access to Medical Records Act 1988 gives you the following principal rights:*

- a. You may withhold your consent for an application for a report.*
- b. You may consent to the application and ask to see a copy of the report before it is sent to us. You will be responsible for making the necessary arrangements with your doctor within 21 days of the report application.*

*If there is anything in the report which you consider is incorrect or misleading you can make a written request to your doctor to amend this but he/she is not obliged to do so, in which case you may:*

- i. Withdraw your consent for the report to be issued;*
  - ii. Ask your doctor to attach to the report a statement setting out your own views; or*
  - iii. Agree to the report being issued unaltered.*
- c. You may consent to the application but indicate that you do not wish to see the report before it is issued.*
  - d. You have the right to seek access to the report at any time up to 6 months after the date of issue.*

## 7. Declaration

*The information given above is complete and correct to the best of my knowledge. I understand that the withholding of medical information may result in disciplinary proceedings against me which may include dismissal.*

*I have read and fully understand my rights under the Access to Medical Records Act 1988 as outlined above.*

*I do  do not  authorise my doctor to provide a medical report.*

*I do  do not  wish to see a copy of any medical report before it is issued.*

Applicant signature

Date

## **8. Pre-employment Medical Questionnaire**

This form is provided as an example to assist with the preparation of a pre-employment medical questionnaire suitable for use within your own organisation. It should not be considered exhaustive or necessarily suitable for use in all circumstances.

The use of a pre-employment medical questionnaire within your employee selection procedures will help to identify individuals who may be unsuitable for certain types of work activity on medical grounds and those who might be accommodated with special provisions.

Where any concerns arise to answers received or further information is required a medical report or examination - always with the candidate's consent - may be necessary.

This is a complex area covered by employment, disability discrimination, health and safety and data protection legislation and legal precedent set in case law. It is therefore absolutely essential that you should seek expert advice from legal and occupational health professionals before implementing pre-employment medical screening.

## **9. Contact us**

For further details of our health and safety consultancy services and how these can benefit your organisation please contact us:

**ISG Consulting Limited**  
**PO Box 129**  
**Burnham-on-Sea**  
**TA8 2YX**

**Phone/Fax (01278) 792737**  
**Email [enquiries@surveygroup.co.uk](mailto:enquiries@surveygroup.co.uk)**  
**Website [www.surveygroup.co.uk](http://www.surveygroup.co.uk)**