Medical History / Declaration

Please complete the following questions by ticking the appropriate column:

1. Have you ever had:	YES	NO
Asthma		
Bronchitis		
Pleurisy		
Heart or circulatory trouble		
Blackouts, Epilepsy, Fainting Attacks		
Skin trouble, rash or sensitivity to Medication – Latex – Food or substances		
Nervous – Anxiety – Depression		
Rupture		
Rheumatism or Arthritis		
Digestive – Bowel disorder – Gastric Disorder or Stomach Problems		
Any order accident, operation or illness, including Jaundice – HIV- Hepatitis		
Recurrent headaches – Migraine		
Have you had a chest x-ray in the past 12 months?		
Do you smoke?		
Back trouble/problems – causing you time off work?		
Neck trouble/problems – causing you time off work?		
Do you have any other health condition which would be relevant to this job role		

If you have answered YES to any of the above, please give further details:

2. Have you seen the Doctor in the past two years?		

If you have answered YES to any of the above, please give further details:

3. Please comment on the status of your current physical and mental health.

Signed: _____ Date: _____

4. Please comment on the status of your immunization status (eg Flu injection, TB etc.)

Signed: _____ Date: _____

5. How many units of alcohol do you drink per week? _____

(one unit = ½ pint of beer or 1 glass of wine)

6. Please comment on the status of your immunization status (eg Flu injection, TB etc.)

WOOD LODGE

7. Please give brief details and approximate dates of any periods of sickness during the last two years

Reason for sickness:

Length of Absence from work _____ days / weeks / months

Reason for sickness:

Length of Absence from work _____ days / weeks / months

Reason for sickness:

Length of Absence from work _____ days / weeks / months

Details of the General Practitioner you are registered with:

GP Name: _____
Address: _____
_____

Tel No: _____

Declaration
I certify that I have answered ALL the questions to the best of my knowledge and that the answers are complete. I give permission for my Doctor to be contacted to certify my fitness to work if necessary.

Signed: _____ Date: _____

For Office Use:
Having reviewed this person's personnel file, interview notes, health questionnaire, I believe that the applicant is/is not* physically and mentally fit for the purposes of the work which the applicant is to perform.

Registered Provider/Manager*: _____* delete as appropriate

Print: _____

Date: _____


WOOD LODGE