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M008/0518

**NEW STARTER ASSESSMENT QUESTIONNAIRE**

**Confidential Information for the Occupational Health Team**

This questionnaire has been issued on behalf of your employer, in order to ensure your employer maintains your health, safety and wellbeing within the workplace.

**General Data Protection Regulation Principals:** (Privacy Policy is available at www.phcohealth.com)

* Data is processed fairly and lawfully, only for specified and lawful purposes and is kept securely.
* Processed data is accurate, adequate, relevant, not excessive, kept up to date and kept no longer than necessary.
* Data is processed in accordance with an individual’s consent and rights.
* Data is not transferred to countries outside of the European Economic Area (‘EEA’) without adequate protection.

□ \*I **consent** to my data being processed and controlled by Preventative Healthcare.

□ \*I **do not** consent to my data being processed and controlled by Preventative Healthcare.

SURNAME: GENDER:

FORENAMES:

COMPANY: BRANCH/DEPOT:

JOB TITLE:

***Please read the questions carefully and write your answers in black ink, as accurately and fully as possible. If you answer YES to any questions, please provide further details in section 13. When completed, please return this form to the Occupational Health Department, marked Private and Confidential. This questionnaire and its contents are strictly confidential to Occupational Health. If the form is not fully completed it will delay the process.***

Date of Birth: (dd/mm/yyyy)

Home Address:

…………………………………………………………………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………Postcode ……………………………………

|  |
| --- |
| Email address: …………………………………………………..@............................................................. |

|  |
| --- |
| Contact Telephone Number: |

**1. OCCUPATIONAL HISTORY**

Please give details of all employment/unemployment over the last five years starting with your present employment. Give details of any work with exposure to lead, asbestos, ionising radiation, noise, chemicals, vibration, risk of HIV and/or Hepatitis B infections.

|  |  |  |  |
| --- | --- | --- | --- |
| **Job Title** | **Employer** | **Dates****FRom To** | **Details of Employment/exposure** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**2. MEDICAL QUESTIONNAIRE**

1. **If you answer YES to any of these questions, *please give full details in section 13 at the***

***end of this document*, including dates, reasons and durations. Not completing fully will**

**delay the assessment of your form.**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **YES** | **NO** |
| 1) | Have you consulted a doctor in the last 24 months? | [ ]  | [ ]  |
| 2a) | Have you ever been a patient at a hospital, nursing home or clinic?  | [ ]  | [ ]  |
| 2b) | Are you at present on a hospital or clinic waiting list, or having any investigations, or under the care of a Specialist? | [ ]  | [ ]  |
| 3) | Have you ever had any investigations/awaiting results of investigations? | [ ]  | [ ]  |
|  | ***If yes, please include the reason, date and result****.* |
| 4)  | Are you currently taking medication (prescribed or not), injections or special diet? | [ ]  | [ ]  |
| 5)  | Have you been absent from work over the past year? | [ ]  | [ ]  |
|  | ***number absences******dates of absences******reasons for absences*** |
| 6)  | Have you ever/do you have any of the following: |
| a) | Chest or heart problems, circulation problems or high blood pressure? | [ ]  | [ ]  |
| b) | Stomach, bowel, liver or kidney problems? | [ ]  | [ ]  |
| c) | Diabetes | [ ]  | [ ]  |
|  | ***If yes, please state whether Type 1 or Type 2 and how this is controlled?*** |  |
|  | ***Date of diagnosis?*** |  |
| d) | Back/joint/muscle problems, arthritis, rheumatism? | [ ]  | [ ]  |
| e) | Depression, anxiety, panic attacks or any other nervous or mental disorder? | [ ]  | [ ]  |
| f) | Epilepsy, giddiness, dizziness, fainting or headaches? | [ ]  | [ ]  |
| g) | Ear, nose or throat, balance problems or hearing issues? | [ ]  | [ ]  |
| h) | Alcoholism/ drug dependency? | [ ]  | [ ]  |
|  | What is your weekly alcohol consumption | …………………….**Units** |
| i) | Have you ever had a formal diagnosis of dyslexia? | [ ]  | [ ]  |
| j) | Do you manage an autism spectrum disorder such as ADHD or Asperger’s? | [ ]  | [ ]  |
| k) | Sinus problems, nose bleeds, hearing, balance or ear problems? | [ ]  | [ ]  |
| l) | Vision or eye problems? | [ ]  | [ ]  |
| m) | Any other health problems not included above? | [ ]  | [ ]  |
|  | For example other diagnosed medical conditions such as blood disorders, ME, CFS, lupus |  |
| 7) | Have you ever had any surgical procedures? | [ ]  | [ ]  |
| 8) | Do you have full use of both arms and legs? | [ ]  | [ ]  |
|  | ***If No, please give details in Section 13*** |
| 9) | Do you have any condition that affects your day to day activity and function? And have you previously required or currently have any adaptations or adjustments to your workplace, work equipment or work vehicle? | [ ]  | [ ]  |
| 10) | Do you consider that you have a condition of any kind that may be covered by disability discrimination legislation? | [ ]  | [ ]  |
| 11) | Do you wear glasses for reading/ distance/ driving? | [ ]  | [ ]  |
| 12) | Do you hold a current EU driving licence? | [ ]  | [ ]  |

|  |  |
| --- | --- |
| 13) | If you answered ‘yes’ to **any** of the questions above, please provide further details below. |
|  |  |

**DECLARATION & CONSENT**

* I declare that the answers contained in this health questionnaire, to the best of my knowledge, are true and complete.
* I understand that the results of this assessment will be passed to my employer. This will include any recommendations advised under disability aspects of the Equality Act 2010.
* I will attend for a health interview/examination if required.
* I will undergo a telephone assessment if required.
* I will provide detailed and complete information regarding my immunization status, as required.
* I have attached copies of specialist reports/investigatory results and details of all current medication.

**CONSENT – Please read and complete the following consent section – either A or B**

|  |  |
| --- | --- |
| **A** | Following assessment of this questionnaire and follow up consultation either face to face or by telephone, I give consent for the Occupational Health Team to make recommendations to my employer **without** **me** having seen the written recommendations. |
|  | Signed………………………………………………………….. | Date………………………………………………………………………… |

**OR**

|  |  |
| --- | --- |
| **B** | I would like to see a copy of the recommendations made by the Occupational Health Team |
|  | \* before they are sent to my employer | [ ]  Yes |
|  | \* at the same time they are sent to my employer | [ ]  Yes |
|  | I would like the copy sent to an email address (provided on page 1) [ ]  Yes [ ]  No |
|  | Signed………………………………………………………….. | Date………………………………………………………………………… |