

Medical Assessment

**PRIVATE
AND
CONFIDENTIAL**

**Height
AB/ 0001**

URN: _____

Name	_____	Job title	_____
Address	_____	NI Number	_____
	_____	Employee No	_____
	_____		_____
	_____	Telephone	_____
Post Code	_____	Mobile	_____

Please provide the following information:

Condition	No	Yes, brief description
How many days have you been absent from work or full time study due to sickness during the last two years		
Have you ever left, or been denied a job for health reasons?		
Have you ever had an illness caused by your work?		
Have you ever experienced any problems when using visual display units?		

Do you have, or have you ever had:

Disease of the heart, circulation, angina, high blood pressure?		
Wheezing, chest tightness, breathing disorder, asthma, lung condition?		
Fear of heights/vertigo?		
Giddiness/difficulty with balance?		
Disease of the brain or nervous system?		
Dizziness or fainting spells?		
Migraine, severe/persistent headache?		
Fits, epilepsy, blackouts?		
Sleep apnoea/sleep related disorder?		
Mental illness, depression, anxiety or any other psychological disorder?		
Bowel disorder, ulcer, hernia?		
Difficult/painful urination?		
Kidney or bladder problem?		
Liver disorder, hepatitis, jaundice?		

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Condition	No	Yes, brief description
Claustrophobia?		
Diabetes?		
Conditions of the bones, joints or limbs? i.e. back/neck pain, pain in arms or hands.		
Problems with climbing?		
Problems working in confined or awkward spaces?		
Problems handling & lifting or manoeuvring loads?		
Hay fever, allergy?		
Skin conditions?		
Eye disorder, colour blindness?		
Visual impairment needing glasses/contact lenses?		
Hearing impairment or other conditions of the ear, nose or throat?		
Are you taking any medication?		
Are you receiving medical treatment?		
Have you consulted a doctor during the past 2 years?		
Have you ever had surgery?		
Have you ever had hospital tests/treatments?		
Does a medical condition or a past injury now affect any of your activities of daily living?		
Do you smoke? (if yes, amount per day)		
Have you ever smoked? (if yes, when did you give up?)		
Do you drink alcohol? (if yes, units per week)		Beer: Wine: Spirits:
Are there any aspects of your health, which you think, are relevant to your proposed work?		
Would you agree to have this information passed to your employer?		

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DECLARATION BY APPLICANT

In signing this questionnaire you confirm that you have read and understood the information given on this questionnaire and that all information provided by you is true to the best of your knowledge. You also accept that if it is subsequently shown that relevant medical information has not been disclosed by you, or has been misleading or false, then you could become liable to disciplinary proceedings by your employer, which may include dismissal. This questionnaire is about health and work. It is NOT an assessment of fitness to join a pension scheme.

In the event of there being a work issue which may be related to your health (or vice versa) we may confirm to your employer, if asked to do so, whether the relevant medical information had been disclosed by you on the questionnaire. This questionnaire will form part of your medical record, which will be kept for a minimum of 40 years.

Nationwide Healthcare Connections complies with Data Protection Legislation and Medical Confidentiality Guidelines and in signing this you confirm that you have given your explicit consent within the meaning of the Data Protection Act 1998 for Nationwide Healthcare Connections to process your personal information with respect to your pre-placement health assessment.

Signed _____

Date _____

Note:

- It is imperative to notify your Human Resources/Personnel contact should there be any significant changes in your health status from the date of signing this questionnaire to commencement of employment. A further assessment of your health may be required.
- Please make sure that you have completed this questionnaire fully and that you have signed the declaration. Failure to do so will delay confirmation of your employment.

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Medical Examination

<i>Mr / Mrs / Miss / Ms</i>					
<i>First Name</i> _____		<i>Last Name</i> _____		<i>Middle initial</i> _____	
<i>Date of birth:</i>	<i>Age:</i>	<i>Height:</i> <i>Metres</i>	<i>Feet</i>	<i>inches</i>	<i>Date of Test:</i>
		<i>Weight:</i> <i>KG</i>	<i>Stones</i>	<i>lbs</i>	_____
<i>Blood Pressure:</i>	<i>2nd reading:</i>	<i>Pulse:</i>	<i>Pulse quality:</i>	<i>Is the urine clear of protein & sugar?</i>	
	<i>3rd reading:</i>			YES / NO reading _____	
COLOUR VISION	VISUAL ACUITY	RIGHT	BOTH	LEFT	Peripheral Vision
Passed	Uncorrected	6/	6/	6/	<i>Body mass index reading:</i>
Failed	Corrected by	6/	6/	6/	
					<i>Must below 20% of candidates ideal weight</i>
<i>Audiometric Test</i>	<u>500</u> <u>1K</u> <u>2K</u>	<i>Muscle Measurement:</i>		<i>Lung function test:</i>	<i>Candidate fit for working at Height: YES / NO</i>
<i>LEFT</i>	Upper arm: Left _____		_____	<i>Confined Space: YES / NO</i>
<i>RIGHT</i>	Right _____			
<i>Physical Fitness test, heart rate reading:</i>	<i>1st reading</i> _____	Stamina test, prsss ups completed without strain:		<i>Signature of Nurse</i>
	<i>2nd reading</i> _____	_____		<i>Registration No:</i>
	<i>3rd reading</i> _____				

Preliminary Clearance by Nurse

General Health	Satisfactory / Unsatisfactory	
Audiometry	Satisfactory / Unsatisfactory	
Vision	Satisfactory / Unsatisfactory	
Colour Vision	Satisfactory / Unsatisfactory	
Physical Fitness	Satisfactory / Unsatisfactory	
Stamina	Satisfactory / Unsatisfactory	

**SCREEN
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Nurses Comments	
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Doctors Comments		
Doctors Signature: (Not present)	<hr/>	Practice Stamp:

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BAR CODE:

**SCREEN
ASSESSMENT**

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Consent under Data Protection Act 1998 and the Access to Medical Reports Act 1988

Personal and medical information provided by you will be retained by Nationwide Healthcare Connections and treated confidentially, i.e. clinical information will not be revealed to your employer without your written consent. However, we may make general recommendations based on the information you have provided. This information will be assessed only by a nurse or a doctor and will be used to advise your employer:

- o How your health could affect your work
- o If any workplace adjustments are needed
- o How the proposed work could affect your health

DECLARATION (Please delete where applicable, sign and complete bottom section if report to be taken up)

I agree to Nationwide Healthcare Connections, as providers of occupational health services, processing personal and sensitive health related information about me

I consent* / do not consent* to the release of relevant clinical information in confidence to my employer. I understand that any advice given to my employer will be expressed in terms of my fitness for employment and / or my fitness to carry out my duties both now and in the future.

GP / CONSULTANT REPORTS

I agree to Nationwide Healthcare Connections applying for information from my own doctor or specialist treating me.

I wish* / do not wish* to see the report before it is sent to the doctor acting for my company.

INDEPENDENT MEDICAL ASSESSMENT

I consent* / do not consent* to attend an independent medical assessment which may include the taking of blood or the need for me to supply a sample of urine, or undergo other investigations, the test results of which will be interpreted by the doctor acting for my company.

I authorise* / do not authorise* the Company Medical Adviser to release medical information from the assessment to my General Practitioner if necessary.

I consent*/ do not consent* that my medical information can be passed between Nationwide Healthcare Connections and my own doctor or specialist.

Please note in the event of a positive Drug & Alcohol result your employer / potential employer has the right to terminate your employment / refuse you employment in conjunction with the Drugs & Alcohol policy XXXXXXXXXXXXX.

I confirm I have read and understood the information about personal data and sensitive data.

I understand that I will be given the opportunity to sign an additional consent form when a new episode of my health occurs, that may affect my occupation.

Last Name: _____

First Name: _____

Signature: _____ Date: _____

Full Address: _____

Post code: _____

Telephone Number: _____

Name of General Practitioner: _____

Full Address: _____

Post code: _____

Telephone No: _____

Name of Consultant: _____

Full Address: _____

Post Code: _____

Telephone No: _____