Annual Health Assessment Questionnaire

Name Date of Birth

Address

Proposed Position Contact Number

Please note that any medical information will remain confidential to Excellent Care Solutions
Have you, within the last year had any of the following: - (Please ✔ as appropriate)

1. Heart and Circulation

Have you ever suffered from a heart attack, chest pains angina, high blood pressure or persistent pains in the leg? **Yes** **No**

If YES - which condition?

What treatment are you receiving?

Details, including how the condition affects you now (including time off work)?

2. Respiratory Problem

Have you ever suffered from bronchitis, asthma, shortness of breath, persistent cough for more than three weeks? **Yes** **No**

If YES - which condition?

Do you use any inhalers? **Yes** **No**

If Yes – which ones?

What treatment are you receiving?

Details, including how the condition affects you now (including time off work)?

3. Psychological Illness

Have you ever had an illness requiring treatment or medication (e.g. depression, anxiety, schizophrenia, stress, drug or alcohol-related problems)? **Yes** **No**

If YES – which condition and what treatment if any are you taking?

How does the condition/treatment affect you now (including time off work)?

4. Special Senses

Do you have any significant problem with your hearing, eyesight, or smell? **Yes** **No**

If YES - which condition?

Details, including how the condition affects you now (including time off work)?

5. Nervous system

Have you ever suffered from any of the following: blackouts, fainting attacks, a stroke, fits or epilepsy, dizzy spells or muscular Weakness? **Yes** **No**

If YES - which condition?

Details, including how the condition affects you now (including time off work)?

Digestive system

Have you ever suffered from digestive trouble (ulcer, colitis, ileostomy, colostomy, irritable bowel syndrome etc)? **Yes** **No**

If YES – which condition?

What treatment are you receiving

Details, including how the condition affects you now (including time off work)?

6A. Are you a diabetic? **Yes** **No**

Treatment (please delete as appropriate) **insulin/tablet/diet controlled**

Does anyone in your immediate family have diabetes **Yes** **No**

Do you consider your diabetes "Well Controlled"? **Yes** **No**

Do you have any problems working shifts or night duties? **Yes** **No**

7. Genito Urinary System

Have you ever suffered from kidney, bladder, reproductive tract, problems? **Yes** **No**

If YES – which condition?

What treatment are you receiving

Details, including how the condition affects you now (including time off work)?

8. Musculoskeletal System

Have you ever suffered from back or neck trouble, rheumatism, arthritis Or other joint/muscle problems? **Yes** **No**

If YES – which condition?

What treatment are you receiving?

Details, including how the condition affects you now (including time off work)?

9. Infectious Conditions

Have you ever suffered from any of the following conditions within the last two years: dysentery or recurring diarrhoea, recurrent boils or sceptic fingers, discharging ears, recurrent infections of the nose and throat **Yes** **No**

Which condition, when and how does it affect you?

10. Skin

Do you suffer with any skin conditions (eczema, dermatitis, psoriasis)? **Yes** **No**

If YES – which condition?

What treatment are you using?

Which part of the body is affected?

How does the condition affect you now (including time off work)?

11. Allergies

Do you suffer from any allergies, hay fever, allergic rhinitis etc? **Yes** **No**

If YES – which condition?

What treatment are you using?

Which part of the body is affected?

How does the condition affect you now (including time off work)?

12. General

Have you ever been retired from work on the grounds of ill health? **Yes** **No**
If YES – please give details

Are you disabled in any way? **Yes** **No**
If YES – please give details

Have you had any medical conditions not mentioned on this form? **Yes** **No**
If YES – please give details, including any treatment

Have you, within the last year had any of the following:- (Please ✔ as appropriate)

1. Unplanned weight change
2. Loss of appetite
3. Sinusitis/recurrent colds
4. Chest pain or tightness
5. Irregular heart beats
6. Shortness of breath
7. Wheeze or cough
8. Indigestion/wind/stomach pain
9. Change in bowel habit or blood in stool
10. Change in bladder function
11. Change in strength of sensation
12. Concentration or memory problems
13. Sleep problems
14. Change in personality or irritability
15. Shortness of breath on hills or stairs
16. Anything else not mentioned

Details please

14. Approximately how many days work have you lost within the past year due to illness or injury?
What were the reasons?

15. How many times have you consulted your doctor in the past year?

16. How much do you smoke?

17. Do you drink alcohol? **Yes** **No**

If yes, please enter how much during an average week

Ordinary beer/lager (1/2 pint) =
Strong beer/lager (1/2 pint) =
Wine Sherry (glasses) =
Spirits (pub measures) =

18. What regular exercise do you take and how many times a month?

19. Do any of your pastimes expose you or your skin or lungs to dust, chemicals, noise or vibration or any other similar hazard?
If so what?

Employee signature Date

Please print name in full

Office Use Only

Medically fit For Proposed Post

Signature Date

Please print name in full