Post-Employment Medical Questionnaire

Private and Confidential

Name:	Date of Birth:		
Address:	Telephone No:		
	Name and Address of Doctor:		
Position:			
	Please Tick	Yes	No
Have you ever suffered from or had investigations for any of the following:			
Diabetes			
Asthma, chest, lung or breathing problems.			
Epilepsy/Fits / Seizures			
Vertigo			
Blackouts/Fainting			
Migraines			
Sight impairment or colour blindness			
Claustrophobia			
Ear, nose and throat problems including hearing impairment			
Heart problems or high or low blood pressure			
Lung problems			
Hepititus			
Varicose veins			
Hernia			
Stomach problems, including peptic ulcers and abdominal organs			
Kidney or bladder problems			
Blood disorder including jaundice			
Musculoskeletal problems including arthritis, back problems, sciatica or rheumatism			
Skin problems			
Tuberculosis			
Allergies			
Nervous Disorder			
Mental Health Issues			
Covid or Long Covid			
Any form of cancer			
Have you ever smoked?			
Are you registered disabled or Are you affected by a physical or mental condition defined as a disability?			
Are you currently taking any prescribed medication?			
If you have answered yes to the above question are there side effects we need to be aware of i.ie makes you drowsy, do not operate machinery? **Please give details in the box at the end of the questions. If you do not declare medication details and side effects / restrictions whilst taking medication to the Company, you may be personally liable if there is an accident at work and may not be covered by our insurance.**			
Have you undergone major surgery?			
Have you suffered from any serious illness not mentioned above?			
Have you ever worked in a noisy environment?			
Have you ever worked with vibrating machinery for significant lengths of time?			
Have you ever worked with asbestos?			

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If you answered Yes to any of these questions please provide details of your condition. The Company reserve the right to refer you to an Occupational Health Specialist so that we can explore if there are any adjustments that we need to make in relation to your work?

Data Protection Notice

The Company requires certain information to ensure you will be able to perform the requirements of the job and give reliable service, and to ensure compliance with relevant Health and Safety regulations. The information is also required to establish whether any reasonable adjustments may need to be made to assist you in performing your duties, in accordance with the Equality Act 2010.

The information you provide will be treated in the strictest confidence and used only for the purposes detailed above in compliance with the General Data Protection Regulation 2018.

Declaration

I confirm that I understand that, as detailed in section 7 of the Health and Safety at Work Act, that I have a duty to take reasonable care for my own health and safety, as well as the health and safety of others who may be affected by my acts or omissions at work.

I understand that if I do not declare medication details and side effects / restrictions whilst taking medication to the Company, that I may be personally liable if there is an accident at work and may not be covered by the company insurance.

I confirm that the information given in this questionnaire is complete and accurate to the best of my knowledge. I understand that I am responsible for informing the company if anything changes with regards to my health or medication that may impact my ability to carry out my role.

Signed: Date: