

R W Simpson Transport Ltd

OCCUPATIONAL HEALTH QUESTIONNAIRE

PART A – PERSONAL DETAILS			
Surname:	Other Names:		
Date of Birth:		Sex:	<i>MALE / FEMALE</i>
Position Applied for:		Location:	
Do you consider yourself to have / have had a disability? <i>YES / NO</i>			
If yes, please give details:			
What is your height?		What is your weight?	
Name of GP / Practice:			
Address:			
			Post Code:
PART B – MEDICAL HISTORY			

Have you **ever** had any of the following? (If **YES**, please tick the appropriate box)

<input type="checkbox"/> Asthma	<input type="checkbox"/> Frequent Coughs & Colds	<input type="checkbox"/> Piles
<input type="checkbox"/> Back / Neck trouble of ANY kind	<input type="checkbox"/> Heart trouble	<input type="checkbox"/> Recurring Headaches / Migraines
<input type="checkbox"/> Chest trouble	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Rupture / Hernia
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney or Bladder trouble	<input type="checkbox"/> Skin Disease / Eczema
<input type="checkbox"/> Dizzy Spells/ Fits/ Blackouts	<input type="checkbox"/> Nervous Disorder / Breakdown	<input type="checkbox"/> Stomach or Bowel problems
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Painful Joints	<input type="checkbox"/> Varicose Veins

PART B – MEDICAL HISTORY Cont'd

1	Do you wear contact lenses / glasses? Do you need them for driving, reading, other? (please specify)	YES / NO
2	Do you have poor hearing in either, or both of your ears?	YES / NO
3	Are you receiving medical treatment, taking any medicines or injections at present? If yes, please give details :	YES / NO
4	Do you suffer from any foot condition preventing the wearing of protective footwear? If yes please give details :	YES / NO
5	Are you allergic to anything you know of? If yes, please give details :	YES / NO
6	Have you ever been recommended to consult or consulted a medical or surgical specialist? If yes, please give details and dates :	YES / NO
7	Have you ever been an in-patient in hospital? If yes please give details and dates :	YES / NO
8	Have you ever had an illness or injury causing you to be off work for over 2 weeks? If yes, please give details and dates :	YES / NO
9	Do you have any disorder or other condition, mental or physical, not already mentioned in any other answer? If yes, please give details :	YES / NO
10	Do you or your blood relatives suffer from sickle-cell disease, thalassaemia, or a blood disorder?	YES / NO
11	Is there anything of a medical nature that you wish to discuss with the Occupational Health Officer in confidence?	YES / NO

PART C – HISTORY OF FAMILY HEALTH

Is there any family history of heart disease, diabetes or any hereditary disorder?

YES / NO

If **YES** , Please give details below:

PART D – NEXT OF KIN / EMERGENCY CONTACT

Name of Contact:

Relationship:

Address:

Post Code:

Telephone Number:

Mobile Number:

Data Protection Act: The information provided within this form may be used for statistical analysis and to administer the company's operations in connection with your employment.

I declare that the above information is correct and complete and I have no other disorder, or condition, mental or physical not already mentioned. I understand that if any of the information is incorrect or if there is any omission then I may become liable to dismissal.

Signature :

Date: