

Pre-employment Medical Questionnaire

PRIVATE AND CONFIDENTIAL

Please complete in block capitals

1. Personal Details

Surname:

Forename(s):

Post applied for:

Department:

Telephone:

Address:

Name and address of GP:



Group Head Office: 70 Boston Road, Beaumont Leys, Leicester LE4 1AW

Tel: 0116 236 6523

Web: www.markgroup.co.uk

2. Occupational History:

Has your employment ever been terminated on the grounds of ill health? Yes No

Approximately how many days sickness absence did you have?

In the last twelve months:

In the year prior to that:

Are you comfortable working at heights Would rather not Yes No

3. Medical History

What is your height

What is your weight

Do you smoke? Yes No
if yes, how many per week?

Are you currently taking prescribed medicine? Yes No
if yes, indicate medication name and for what?

Are you currently under the care of a doctor or other medical professionals? Yes No
if yes, indicate for what?

Have you ever previously sustained any injuries as a result of an accident, whether at work or otherwise? Yes No
if yes, indicate injuries sustained, treatment and date

Have you ever previously been diagnosed with suffering any form of recognised occupational illness or condition? Yes No
if yes, indicate illness or condition, treatment and date?

Are you allergic to penicillin, tetanus or any other medication. Are you allergic to wasp or bee stings? Yes No
if yes, indicate which?

Do you expect to ask for leave of absence for medical reasons during the next 12 months? Yes No
if yes indicate approximate dates and for what?

When did you last consult your GP and why?

4. Additional Information

5. Declaration

PLEASE READ CAREFULLY BEFORE SIGNING

1. I declare the above information to be true and accurate in every respect. I understand and accept that the provision of false information would be a breach of trust, sufficient to allow my employer to take disciplinary action, which may result in my dismissal.
2. I consent under Data protection legislation to the company processing the information I have provided on this questionnaire for the purpose of assessing my health and suitability for employment. I understand and agree that the information will be retained for as long as the company deems necessary and that the information may be passed to a third party such as medical assessor for comments.
3. Although I understand that I have the right to refuse, I hereby give my permission for the company / company doctor to approach my own medical practitioner for further and better particulars of my medical history / records should the company / company doctor so decide and for the submission of these facts / medical report to the company.

I understand that should this prove necessary, I have the following rights:

- A) To have access to the report prior to it being supplied to the company. I understand that I may be charged if I request a copy. I do / do not* wish to exercise this right (*please delete as appropriate) I understand that if I choose not to exercise this right, I have the right to have access to the report at any time during the six months following issue.
 - B) If I exercise my rights under A) above and do not respond to my doctor within 21 days of the application for the report, I understand that the report will be forwarded to the company.
 - C) That within 21 days referred to in B) above, I may request my doctor in writing to amend any part of the report which I consider to be misleading or incorrect and, if the doctor is not prepared to do so, that a statement of my views is attached to the report prior to being sent to the company.
4. I am prepared to undergo a full medical examination at the company's request if it is required.

Signed

Printed

Date

Have you at any time suffered from or had any symptoms of the following complaints?

(If so, please give further details in the space provided)

Depression, anxiety, stress, nervous illness or breakdown Yes No

Fainting attacks, fits or any disease of the nervous system e.g. epilepsy Yes No

Persistent cough, asthma, pleurisy, bronchitis or any other ailment of the respiratory system Yes No

Rheumatism, arthritis, joint or tendon disorder e.g. tenosynovitis or repetitive strain injury e.g. carpal tunnel syndrome Yes No

Back or neck pains. Disc damage or other spinal injury or condition Yes No

Chest pains, shortness of breath, raised blood pressure or other ailment of the heart or circulatory system Yes No

Any ailment affecting the eyes (indicate if colour blind) Yes No

Ailment affecting the ears Yes No

Ailment affecting the nose or throat e.g. hay fever Yes No

Ailment affecting the hands or fingers e.g. blanching, tingling or numbness Yes No

Skin disorders e.g. eczema, contact dermatitis Yes No

Any injury, operation or physical abnormality Yes No

Have you ever had any special medical investigation, X-ray, Cardiogram, blood or urine test? Yes No

Any illness, ailment or disorder not mentioned above Yes No
