CONFIDENTIAL HEALTH QUESTIONNAIRE NAME.: ……………………………

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| --- | --- |
| Do you suffer, or have you ever suffered from any chest disease, pain, angina or heart trouble or disease? | YES / NO |
| Do you suffer, or have you ever suffered from epilepsy, fits, blackouts, fainting or unexplained loss of consciousness? | YES / NO |
| Do you suffer, or have you ever suffered from head injuries leading to loss of consciousness requiring hospital admission? | YES / NO |
| Do you suffer, or have you ever suffered from gastric or duodenal ulcers? | YES / NO |
| Do you have any skin disease or have you ever suffered from the same? | YES / NO |
| Do you suffer, or have you ever suffered from any blood pressure anomalies or blood disorders? | YES / NO |
| Do you suffer, or have you ever suffered from a back injury or related complaint? | YES / NO |
| Do you suffer, or have you ever suffered from any eyesight problems? (i.e. any difficulty which is not corrected by spectacles or contact lenses) e.g. colour blindness, field defects, cataracts, glaucoma | YES / NO |
| Do you suffer, or have you ever suffered from any hearing problems? | YES / NO |
| Do you suffer, or have you ever suffered from recurrent headaches or migraine? | YES / NO |
| Do you suffer, or have you ever suffered from asthma, bronchitis, emphysema or any other lung disorder? | YES / NO |
| Do you suffer, or have you ever suffered from anxiety, depression, phobias, mental breakdown or stress related problems? | YES / NO |
| Do you have any disabilities which may need to be assessed in connection with your application? A disabled person is a person with a *‘physical or mental impairment which has a substantial or long term effect on his/her ability to carry out normal day-to-day activities.*’  Using this definition, would you consider yourself to be disabled?/ | YES / NO  YES / NO |
| Have you claimed for industrial injuries or received compensation at common law against a previous employer? | YES / NO |
| If you have answered YES to any of the above, please describe: | |
| Have you ever had any serious Illness, Operation or Accident? YES / NO | |
| If YES, please give details: | |
| How many days absence have you had in the past two years? ………………….. Days | |
| Are you currently under the care of a doctor or other medical professional or having any medical treatment or medication?  If yes please specify:  Is there any other matter concerning your health not covered by the above questions? | |

Please note a **YES** answer does **NOT** mean you will be automatically rejected for employment. You should provide as much detail to your answer as possible. **Please delete as appropriate:**

Signature of applicant: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_