



Working with Dunans Occupational Health

PRE EMPLOYMENT HEALTH ASSESSMENT

Section 1 - To be completed by the applicant. Please read this form all the way through before starting to complete it.

The purpose of this pre employment health assessment is to ensure, so far as is possible, that you are fit for the post you have applied for in order to protect your own and others' health and safety.

Questions are asked about your past and present health, medical treatment and any impairment that may have implications for your health and safety. The information you provide will remain confidential to APR Agency and Dunans Occupational Health if further screening is required.

If you have any difficulties in completing this form or wish to discuss any issues in a confidential setting, please contact APR Agency 01522 536020 or Dunans Occupational Health on 0845 094 3139 or 0776 670 8159 for advice.

Declaration: I declare that all of the following statements and information is true to the best of my knowledge and that failure to disclose information may result in termination of my employment.

Signed: _____ Date: ___/___/___



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Section 2 – Consent

If required I consent to Dunans Occupational Health requesting my General Practitioner and/or appropriate Specialist(s) to provide reports as considered necessary. I understand that this consent in no way diminishes my rights to see such reports before they are submitted, under the terms of the Access to Medical Reports Act 1988.

Signed: _____ Date: ___/___/___

GP NAME: _____

ADDRESS: _____

Section 3 - Personal Details

Last name:	First name:
Date of Birth:	Sex: Male:() Female: ()
Address:	Name and address of your G.P. / family doctor:
Postcode:	Postcode:
Telephone Number:	

Section 4 - Questions about your health.

Please answer all of the following questions. If you answer YES please give details in the space provided in Section 8 at the back of this form.

		Yes	No	Don't know
1	Do you have any impairment that may affect your ability to work safely?			
2	Do you have any eyesight problems not corrected with glasses/ contact lenses?			
3	Do you have any hearing problems not corrected with a hearing aid?			
4	Do you have any difficulty in standing, bending, lifting or other movements?			
5	Have you seen a doctor in the past 12 months for any kind of health problem?			
6	Are you currently having any treatment or investigations?			



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		Yes	No	Don't know
7	Are you currently waiting for any treatment or investigations of any kind?			
8	Have you ever has any skin problems?			
9	Have you ever had any back problems?			
10	Have you ever had any problems with your joints including pain, swelling or stiffness?			
11	Have you ever had any mental illness or psychological problems?			
12	Have you ever had any drug or alcohol problems?			
13	Have you ever had fits, blackouts or epilepsy?			
14	Do you have any allergies?			
15	Have you ever had asthma, bronchitis, or other chest problems?			
16	Have you ever had treatment for tuberculosis (T.B.)?			
17	In the past 12 months, have you had a cough for more than 3 weeks, ever coughed blood or had any unexplained weight loss or fever?			
18	Have you ever had hepatitis or jaundice?			
19	Have you ever had diabetes, thyroid or other gland problems?			
20	Do you have any other medical conditions?			
21	Have you ever had any illness that may have been caused by or made worse by your work?			
22	Females only: Do you have any gynaecological problems?			

Section 5 – Have you been exposed to any of the following chemicals, hazardous materials or working environments? Please give dates where known.

	Yes	From - To		Yes	From - To
Agriculture			Cement		
Brickworks			Chromium compounds		
Feed Mills			Cotton, flax or hemp		
Foundry			Excessive noise		
Mines			Excessive vibration		
Pottery			Formaldehyde		
Quarries			Isocyanates		
			Lead compounds		
Achrylonitrile			Mineral fibres		
Analyine dyes			Other dusts		
Asbestos			Platinum compounds		
Benzene			Radioactive substances		



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Section 6- Immunity Review. Please indicate below whether you have been vaccinated or have had the illness during your lifetime. Where possible, please provide evidence of your immunity. This can be obtained from your GP / family doctor. If you are unable to provide proof, you will be subject to blood tests to ascertain this prior to commencing employment.

Disease	History Of Disease?	History of Vaccination?	Evidence Provided? (✓)
Hepatitis B		<i>Dates of Primary Course :</i> Vaccine 1 Vaccine 2 Vaccine 3 5 yr booster / review:	
Disease	History of Disease?	History of Vaccination?	Evidence Provided?
Hepatitis A			
Measles			
Mumps			
Rubella			
Tetanus			
Polio			
Diphtheria			
Tuberculosis			

Section 7 – To be completed by food handlers only. Please answer all of the following questions. If you answer YES please give details in the space provided in Section 9 at the back of this form.
Do you have or have you had any of the following:

	Yes	No		Yes	No
Discharging eye(s)			Frequent attacks of diarrhoea or loose stools		
A running or discharging ear(s)			Abdominal pain		
Dental problems			Fever		
A cough producing sputum			Typhoid or paratyphoid fever		
Repeated sore throat			Varicose veins		
Acne, boils or styes			Scaling or weeping rashes		
Septic finger			Psoriasis		
Known allergy to any foodstuffs					
Have you travelled abroad in the past 3 months?					



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<p>If yes, have you experienced</p> <ul style="list-style-type: none">• flu-like symptoms?• Sickness and diarrhoea?• Abdominal pain• Fever• Frequent attacks of diarrhoea or loose stools			<p>Have you been in contact with anyone suffering from</p> <ul style="list-style-type: none">• Typhoid ?• Paratyphoid ?• Hepatitis A ?• Cholera ?		
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Section 8 – Additional information



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FOR OCCUPATIONAL HEALTH USE ONLY

Date Received	
Date Assessed	
Date certificate of fitness sent to manager/HR	

Based solely on the information provided by the applicant:

Fit for employment	
Fit for Employment – vaccination review required upon commencement of employment	
Fit with restrictions (please indicate below)	
Decision deferred pending investigation results	
Decision deferred pending GP/Consultant report	
Unfit for proposed employment	
Referred to OHP for further assessment	

Signed:

Designation:

Date:

Review Date: