Middlesex University London

Please complete this form in BLACK pen and BLOCK CAPITALS and keep a PHOTOCOPY & Take to your appointment

OCCUPATIONAL HEALTH QUESTIONNAIRE – CONFIDENTIAL

Your answers to this questionnaire will be **CONFIDENTIAL** to the Occupational Health Service Information will not be released to anyone else without your permission. The purpose of the questionnaire is to see whether you have any health problems that could affect your ability to undertake nurse training or practice or place you at any risk in this. We may recommend certain special requirements or restrictions as a result. We also ask about matters which may not affect your ability to train, but about which we may be able to offer you help and advice. Our aim is to promote and maintain the health of students in the hospital.

PLEASE HELP US TO HELP YOU BY COMPLETING THE QUESTIONNAIRE AS FULLY AS POSSIBLE.

Surname/Family Name: _____ Former Name: _____

First Name: _____ Male ☐ Female ☐

Present Address: _____

_____ Post Code: _____

Telephone No : _____ Date of Birth: _____

Name and Address of General Practitioner: _____

_____

_____

Telephone No: _____ Fax No: _____

Course applied for: _____ Department _____

Previous employment in the last 3 years

Employer	Nature of your work	Start date	Finish date

Do you consider yourself to have a disability? Yes ☐ No ☐

We comply with the Disability Discrimination Act 1995 and its Code of Conduct. If you consider that you have a disability that may affect you in your work, you should state this. We can then help assess and advise on what adjustments or assistance may be needed to enable you to do the job.

If yes, please give details: _____

_____

Please answer all the following questions. If you answer 'Yes' to any of the questions, ***please give details as completely as possible on the back page*** **Incomplete information will lead to delays**		Please delete as applicable	Dates
1.	Have you been away from work or study because of ill health during the last two years?	YES/NO	
2.	Have you ever had an operation or serious illness?	YES/NO	
3.	Have you been seen or treated by a doctor or other health professional in the past two years?	YES/NO	
4	Have you any reason to think you may have reduced immunity due to medication or a medical condition including HIV?	YES/NO	
5.	Do you have diabetes?	YES/NO	
6.	Have you ever had any dizzy spells, epilepsy, fits or blackouts?	YES/NO	
7.	Have you ever had back problems (including the neck)?	YES/NO	
8.	Do you have arthritis, joint or limb problems?	YES/NO	
9.	Have you ever seen a doctor or health professional for anxiety, depression or any other psychiatric or psychological problem?	YES/NO	
?	Have you ever had any problems related to alcohol or drug misuse?	YES / NO	
10	Have you ever seen a doctor or health professional because of eating problems?	YES/NO	
11.	Do you have hearing loss or other ear problems?	YES/NO	
12.	Do you have any eyesight problem (which is not corrected by glasses or contact lenses)	YES/NO	
13.	Are you colour blind?	YES/NO	
14.	Do you have dyslexia?	YES/NO	
15.	Do you have any allergies?	YES/NO	
16.	Do you have hay fever, asthma or other chest condition?	YES/NO	
17.	Do you have any of the following: ❑ A cough which has lasted for more than 3 weeks? ❑ Unexplained weight loss? ❑ Unexplained fever?	 YES/NO YES/NO YES/NO	
18.	Have you ever had tuberculosis (TB) or been in recent contact with open TB?	YES/NO	
19.	Have you ever had a skin problem? If so, which part of the body was/is affected?	YES/NO	
20.	Have you a skin problem now?	YES/NO	
21.	Have you ever had hepatitis or jaundice?	YES/NO	
22.	Do you have frequent diarrhoea or other bowel disorder?	YES/NO	
23.	Are you taking any pills (other than the contraceptive pill), tablets or medicines at present?	YES/NO	
24.	Have you ever had a health problem caused by your work?	YES/NO	
25.	What is your weight? Kgs Stones/pounds		
26.	What is your height? Cms Feet/inches		
27.	Have you ever tested positive to any of the following: HIV Antibodies Hepatitis B surface antigen Hepatitis B core antibodies Hepatitis C antibodies	 YES/NO YES/NO YES/NO YES/NO	

28 .	**Clinical diagnosis and management of tuberculosis, and measures for its prevention and control (2006)** Have you lived outside of the UK in any country **for more than three months** in the last 5 years? Yes ☐ No ☐ If Yes, please list **all** of the countries that you have lived in (over the last 5 years) _____

If you have answered **YES** to any of the previous questions please write details **AS FULLY AS POSSIBLE IN THE SPACE BELOW.** (complete on separate sheet if necessary)

Question No	Details

CHECKLIST

- Have you answered **all** of the questions with **dates** and **further information** as required?
- Has your **GP** completed the relevant section?
- Have you included the **dates** of all your **immunisations**?

DECLARATION

I declare that the answers to the above questions are true and complete to the best of my knowledge and belief. I give permission for the Occupational Health Service to communicate with my own General Practitioner or any other doctor/specialist, if further information is required and for the doctor concerned to give details of my clinical condition to the Occupational Health Nurse Adviser/Physician. I understand that failure to declare any health condition may result in withdrawal of the offer of a place on this training course.

I understand that I shall be advised if a report is being requested and that under the Access to Medical Reports Act, 1988:

- I have the right to see the report before it is sent.
- I am entitled to ask the doctor to amend or modify information which I consider is inaccurate
- I have 21 days from notification to seek access to the report

❖ **I DO WISH / DO NOT WISH TO SEEK ACCESS TO THIS REPORT**
(please delete)

Signature: _____ Date: _____

TO BE COMPLETED BY THE OCCUPATIONAL HEALTH SERVICE

Further information requested YES / NO

Details _____

Health Clearance Given YES ☐ _____ _____

Restrictions / adjustments / further assessment recommended. Yes □ No □
(For details see fit form and/or cover letter)

Signed Date

You are required to consult your General Practitioner to complete the information listed below about your general heath and immunisation programme prior to commencing your course at Middlesex University. It is important that you arrange to have any vaccination or screening that you have not already had.
Note : If you are under 25 years old, you should be able to access your school health record through the relevant Primary Care Trust/ school health records. Search NHS Trusts for your last school area on http://www.nhs.uk/servicedirectories/Pages/ServiceSearch.aspx

TO BE COMPLETED BY THE CANDIDATES GENERAL PRACTITIONER:

How long have you known the candidate? ……

How many times have you seen him/her in the last 5 years? ……

Please tick which of the following childhood illnesses s/he has had:

Measles ☐ **Mumps** ☐ **Chickenpox** ☐

Is there any significant history of physical or mental disorders, including eating problems: Yes ☐ No ☐
If 'Yes', please give details

Are there any physical abnormalities that you are aware of? Yes ☐ No ☐
If 'Yes', please give details (on separate sheet if necessary)
This may be based on your knowledge of the student and from the medical notes, a physical examination is not required.

From your knowledge of the candidate, would you say that s/he is temperamentally and physically suitable to study and practice to become a registered nurse?

Yes ☐ No ☐

Vaccination	Dates			Vaccination	Dates
Tetanus	1	2	3	Rubella	
Polio				Measles	
Diphtheria				Mumps	
Hepatitis B				MMR	
Hepatitis B boosters				BCG BCG Scar present? YES/NO	
Varicella				Mantoux/Heaf test Result in mms / Grade	
Meningitis				Chest Xray (if done in last 2 years) Result :	

Health clearance to commence nurse training cannot be issued until all sections of the health questionnaire have been completed and submitted to the relevant Occupational Health Department.

Thank you for your cooperation

Name of Doctor (Please print _____

Address _____

Signed _____ Date _____

Practice Stamp: