Please complete this form in full and keep a HARD COPY to take to your Occupational Health appointment

OCCUPATIONAL HEALTH (OH) 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-related problems that could affect your ability to undertake any aspect of your healthcare programme (university or placement) or place you at any risk in this. The OH team may recommend certain special requirements or restrictions as a result that need to be taken into consideration by the university prior to confirming you are able to undertake all aspects of this programme safely. We also ask about matters which may not affect your ability to undertake the programme, but about which we may be able to offer you help and advice. Our aim is to promote and maintain the health of students working in health and social care environments.

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

Personal Information

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other

If Other, please specify here _____

First Name: _____

Surname: _____

Former First Name: _____

Former Surname: _____

Current Address: _____

_____ **Post Code:** _____

Date of Birth: _____ **Gender:** ☐ Male ☐ Female

Telephone Number: _____

Email Address: _____

Programme Information

Middlesex University Student ID: _____

Programme applied for: Choose from options

If Other, please specify here _____

General Practitioner (GP) Information

Name and Address of General Practitioner (GP): _____

_____ **Post Code:** _____

Telephone Number: _____ **Fax Number:** _____

Employment Information

Please provide details of your employment history for the last 3 years.

Employer	Nature of your work	Start date	Finish date

Health Information

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

We comply with the Equality Act 2010. 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 undertake all aspects of the programme.

If yes, please give details:

Please answer all the following questions. If you answer 'Yes' to any of the questions, ***please provide details as fully as possible on page 5.*** **Incomplete information will lead to delays.**		**Please select 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	
10.	Have you ever had any problems related to alcohol or drug misuse?	☐ Yes ☐ No	
11.	Have you ever seen a doctor or health professional because of eating problems?	☐ Yes ☐ No	
12.	Do you have hearing loss or other ear problems?	☐ Yes ☐ No	
13.	Do you have any eyesight problem (which is not corrected by glasses or contact lenses)?	☐ Yes ☐ No	
14.	Are you colour blind?	☐ Yes ☐ No	
15.	Do you have dyslexia?	☐ Yes ☐ No	
16.	Do you have any allergies?	☐ Yes ☐ No	
17.	Do you have hay fever, asthma or other chest conditions?	☐ Yes ☐ No	
18.	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	

19.	Have you ever had tuberculosis (TB) or been in recent contact with open TB?	☐ Yes ☐ No	
20.	Have you ever had a skin problem? *If so, which part of the body was/is affected?*	☐ Yes ☐ No	
21.	Have you a skin problem now?	☐ Yes ☐ No	
22.	Have you ever had hepatitis or jaundice?	☐ Yes ☐ No	
23.	Do you have frequent diarrhoea or other bowel disorders?	☐ Yes ☐ No	
24.	Are you taking any pills (other than the contraceptive pill), tablets or medicines at present?	☐ Yes ☐ No	
25.	Have you ever had a health problem caused by your work?	☐ Yes ☐ No	
26.	What is your weight? Kgs		Stones/pounds
27.	What is your height? Cms		Feet/inches
28.	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	
29.	Have you had any of the following: ❖ Measles? ❖ Mumps? ❖ Chickenpox?	 ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	
30.	Have you ever tested positive to Covid-19?	☐ Yes ☐ No	
31.	Do you suffer from any ongoing health issues post Covid-19?	☐ Yes ☐ No	
32.	**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 questions on pages 3 & 4, please write details **AS FULLY AS POSSIBLE IN THE SPACE BELOW.** (complete on a separate sheet if necessary)

Question No	**Details**

Please provide details regarding immunisations/vaccinations you have received – providing dates where possible *(your GP may be able to support with this information)*

Vaccination	**Dates**			**Vaccination**	**Dates**
	1st dose	**2nd dose**	**3rd dose**		
Tetanus				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 the last 2 years) *Result:*	
COVID-19			N/A		

Checklist

- Have you answered **all** of the questions with **dates** and **further information** as required?
- 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 (select to declare):

- ☐ 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 understand that the OH report/recommendations must be reviewed by the university to ensure that any reasonable adjustments can be effectively implemented /applied to enable me to undertake my programme of study safely.

❖ **I ☐ DO WISH / ☐ DO NOT WISH TO SEEK ACCESS TO THIS REPORT.**
(please select one)

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)

Signature: _____ **Date:** _____