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| **HEALTH QUESTIONNAIRE** | | | | | | | | | | | | | | | | | | | | |
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| **Guidance Notes:**  The purpose of thisquestionnaire is to provide information about your health which will assist in the following ways:   * To ensure that you are medically suitable for the proposed job; * To advise, where necessary, on any reasonable adjustments required to enable you to safely carry out the duties; * To ensure that you do not have a medical condition which may pose a risk to your safety or to that of your colleagues, service users or members of the public; * To help us identify if there is a risk of developing a work related illness from any hazards within the workplace.   The information provided by you will be treated in the strictest confidence and will only be disclosed to our Occupational Health Advisers, Human Resources and, if relevant, your manager. | | | | | | | | | | | | | | | | | | | | |
| **PLEASE ENSURE THAT YOU COMPLETE ALL SECTIONS OF THIS FORM. FAILURE TO DO SO WILL RESULT IN A DELAY TO YOUR HEALTH CLEARANCE AND APPOINTMENT TO POST.**  **WHEN COMPLETE E-MAIL FORM TO:** [icpe@ipohs.co.uk](mailto:icpe@ipohs.co.uk) | | | | | | | | | | | | | | | | | | | | |
| **Post Applied For:** | | | |  | | | | | | | **Service:** | Choose an item. | | | | | | | | |
| **Personal Details** | | | | | | | | | | | | | | | | | | | | |
| Name: | | | |  | | | | | | | Contact Tel No: | | | | |  | | | | |
| Address: | | | |  | | | | | | | Date of Birth: | | | | |  | | | | |
| Post code: | | | |  | | | | | | | Height: | | | | |  | | | | |
| Town: | | | |  | | | | | | | Weight: | | | | |  | | | | |
| E-mail address: | | | |  | | | | | | | Is your weight…… | | | | | Choose an item. | | | | |
| **Occupational History/Past Employment** | | | | | | | | | | | | | | | | | | | | |
| Current or Most Recent Job: | | | |  | | | | | | | Date Commenced: | | | | | | |  | | |
| Have you ever suffered from an industrial disease or had a serious industrial incident? | | | | | | | | | | | | | | | | | | Choose an item. | | |
| If YES, please provide further details below: | | | | | | | | | | | | | | | | | | | | |
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| Have you ever been advised for medical reasons not to do night work, shift work, or any kind of work? | | | | | | | | | | | | | | | | | | Choose an item. | | |
| If YES, please provide further details below: | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| Have you ever been retired or had your employment terminated on ill health grounds? | | | | | | | | | | | | | | | | | | Choose an item. | | |
| If YES, please provide further details below: | | | | | | | | | | | | | | | | | | | | |
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| **Medical History** | | | | | | | | | | | | | | | | | | | | |
| Are you currently receiving any treatment or regular medication supervised by your GP or Specialist? | | | | | | | | | | | | | | | | | | Choose an item. | | |
| If YES, please provide further details below: | | | | | | | | | | | | | | | | | | | | |
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| Have you ever had any illnesses, operations, or injuries that have caused you to be off work for more than 4 weeks? | | | | | | | | | | | | | | | | | | Choose an item. | | |
| If YES, please provide further details below: | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| Have you been absent from work for more than 9 days and/ or on 4 or more occasions during any 12 month period over the last 3 years? | | | | | | | | | | | | | | | | | | Choose an item. | | |
| If YES, please provide further details below: | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| Do you have any current or previous health factors which may have an impact on your ability to safely carry out the duties of the post? | | | | | | | | | | | | | | | | | | Choose an item. | | |
| If YES, please provide further details below: | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| Do you have eyesight problems? | | | | | Choose an item. | | | Do you wear glasses/ lenses? | | | | | | | | | | Choose an item. | | |
| Do you have problems with hearing? | | | | | Choose an item. | | | Do you wear a hearing aid? | | | | | | | | | | Choose an item. | | |
| Do you have problems with mobility? | | | | | Choose an item. | | | Do you use a wheelchair or any walking aids? | | | | | | | | | | Choose an item. | | |
| Do you smoke? | | | | | Choose an item. | | | How many cigarettes per day? | | | | | | | | | |  | | |
| Do you drink alcohol? | | | | | Choose an item. | | | How many units per week? | | | | | | | | | |  | | |
| Have you ever had an addiction to drugs or alcohol? | | | | | | | | | | | | | | | | | | Choose an item. | | |
| Do you have, or have you ever suffered from: (please choose an item) | | | | | | | | | | | | | | | | | | | | |
| Eye problems | | Choose an item. | | | | Ear/ Nose/ Throat problems | | | | | Choose an item. | | Infectious diseases | | | | | | | Choose an item. |
| Heart problems | | Choose an item. | | | | Lung/ breathing problems | | | | | Choose an item. | | Epilepsy | | | | | | | Choose an item. |
| Liver problems | | Choose an item. | | | | Kidney/bladder problems | | | | | *Choose an item.* | | Blood disorders | | | | | | | Choose an item. |
| Diabetes | | Choose an item. | | | | Stomach/ bowel problems | | | | | Choose an item. | | Migraines | | | | | | | Choose an item. |
| High blood pressure | | Choose an item. | | | | Circulation problems | | | | | Choose an item. | | Frequent headaches | | | | | | | Choose an item. |
| Thyroid trouble | | Choose an item. | | | | Skin problems | | | | | Choose an item. | | Nerve disease | | | | | | Choose an item. | |
| Joint Trouble: Arthritis/ backache/ sore neck/ shoulder/ sciatica | | | | | | | | | | | | | | | | | | | Choose an item. | |
| Mental Health problems: depression/ anxiety/ psychosis/ stress/ nervous debility | | | | | | | | | | | | | | | | | | | Choose an item. | |
| Is there any history of heart or circulation issues, lung disease, diabetes, high blood pressure, or mental health problems in your family? | | | | | | | | | | | | | | | | | | | Choose an item. | |
| If you have ticked any of the previous boxes in the medical history section, or have experienced any other illnesses, conditions or operations not previously mentioned, please provide further details below: | | | | | | | | | | | | | | | | | | | | |
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| **Equality Act** | | | | | | | | | | | | | | | | | | | | |
| In accordance with the terms of the Equality Act 2010, Inverclyde Council supports the principles of equal opportunities in employment and will consider all reasonable adjustments that allow an employee or prospective employee with a disability to carry out their role effectively. Under the terms of the Act, a disability is defined as a physical or mental impairment that has a substantial and long term adverse effect on an individual’s ability to carry out normal day to day activities. | | | | | | | | | | | | | | | | | | | | |
| Do you consider yourself to be disabled : | | | | | | | | | | | | | | | | | | | Choose an item. | |
| To ensure compliance with the Act, please detail below any aids/adaptations/adjustments required to assist you at work: | | | | | | | | | | | | | | | | | | | | |
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| Declaration | | | | | | | | | | | | | | | | | | | | |
| I consider myself to be both physically and mentally fit for the post and able to provide regular and effective service to Inverclyde Council. I certify that all statements given above by me on this form are true and correct to the best of my knowledge. I understand that if I am employed and it is found that such information is false or that I have withheld or misrepresented information, I am liable to dismissal on the grounds of gross misconduct. You are giving consent for the examination/release of the report to Inverclyde Council. | | | | | | | | | | | | | | | | | | | | |
| Signature  (type name): | | |  | | | | | | Date: | | | | |  | | | | | | |
| **CHECK ALL BOXES HAVE BEEN COMPLETED AND E-MAIL FORM TO:** [icpe@ipohs.co.uk](mailto:icpe@ipohs.co.uk)  Candidates must regularly check e-mail (including junk mail) in case OH provider contacts you. | | | | | | | | | | | | | | | | | | | | |
| For Medical Use Only | | | | | | |  | | |  | | | | | | |  | | | |
| Screened by: | | | | | | | | | | | | | | | | | | | | |
| Opinion: | | | | | | | | | | | | | | | | | | | | |
| Signature: |  | | | | | | | | Date: | | | | | |  | | | | | |

***Data Protection****: Inverclyde Council is obliged to comply with current Data Protection Laws and will use this information for the purposes of  processing your personal information for the performance of a contract with you and related purposes. Further information can be found at* [*www.inverclyde.gov.uk/privacy*](http://www.inverclyde.gov.uk/privacy)