

## MENTAL HEALTH

# Medical Questionnaire

### Strictly Private and Confidential

You are requested to answer the following questions about your health so that we may:

1. Establish whether reasonable adjustments may be necessary to enable you to carry out your duties.
2. Establish whether you are able to carry out a function that is intrinsic to the work concerned.

PLEASE WRITE CLEARLY IN BLACK INK.

#### 1. Personal details (BLOCK CAPITALS PLEASE)

Full name	
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#### 2. General Practitioner details

Name	
Address	
Telephone no.	

#### 3. Equality Act 2010

The Equality Act 2010 defines a person with a disability as someone with 'a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities'.

Do you have a disability which may affect your ability to undertake your role or which requires special arrangements? (circle your answer)	YES	NO
If YES, what facilities/adjustments/equipment might enable you to perform the role?		

#### 4. Medical Records

Have you ever had any of the following?		Please circle your answer		If YES, please give details
<b>1</b>	Epilepsy, fits, blackouts, fainting turns, or unexplained loss of consciousness?	YES	NO	
<b>2</b>	Vertigo, dizziness, giddiness, problems with balance?	YES	NO	

<b>3</b>	Recurrent headache or migraine?	YES	NO	
<b>4</b>	Diseases of the nervous system, e.g. neuritis, stroke, multiple sclerosis?	YES	NO	
<b>5</b>	Chest pain, angina, heart disease, breathlessness?	YES	NO	
<b>6</b>	Any visual defect, e.g. scotoma, blindness in one eye, reduced visual field, blurred vision, colour blindness?	YES	NO	
<b>7</b>	Asthma, bronchitis, emphysema, pneumonia or any other lung disease?	YES	NO	
<b>8</b>	Arthritis, gout, chondromalacia patellae or rheumatism?	YES	NO	
<b>9</b>	Any metabolic disorder including diabetes, thyroid and adrenal gland disease?	YES	NO	
<b>10</b>	Psoriasis, eczema, allergic skin rash or other skin disorder?	YES	NO	
<b>11</b>	Anxiety/depression, mental breakdown or stress related problems?	YES	NO	
<b>12</b>	Any allergies, including hayfever?	YES	NO	
<b>13</b>	Ear or hearing problems?	YES	NO	

Do you have any other Mental or Physical impairment not specified above which may affect your employment in this job role? If Yes, please specify

If you have answered YES to any of these, what facilities/adjustments/equipment might enable you to perform the role?

## 5. Past medical history

Has any previous occupation caused you health problems?	YES	NO
If YES, please provide details		

## 6. Declaration

I declare that the information given in this questionnaire is true and complete. I understand that any misleading information or any omissions will be sufficient grounds for the termination of my employment.

I will notify you immediately if any of my answers change on my completed questionnaire or if I develop any condition which may affect the health and safety of myself or others.

Name	
Signature	
Date	

The information provided by you on this form will be stored either on paper records or a computer system in accordance with the General Data Protection Regulations (GDPR) (EU) 2016/679 for a specific time in accordance with our Data Retention Policy.