General Health Questionnaire

Please complete all parts by ticking the boxes and providing details where appropriate. At the end of the form you will be asked to sign to say that you have answered the questions truthfully.

Medical information you provide will remain confidential to Occupational Health and Wellbeing unless the information will have a detrimental effect on your working or others Health and Safety.

Your personal details

Surname		Address	Employer
Forename(s)		Postcode	Location
Date of birth	National Insurance number	Telephone (home) Telephone (work)	Job

Approximate date of last medical examination? ……………………………………………………

Why are you having a medical examination at Occupational Health & Wellbeing today? State:
……

Part 2 Medical history

Have you ever had any problems with the following?	Yes	No	If yes, please give details
1. Fits, epilepsy, blackouts unsteadiness?			
2. Disease of the brain or nervous system?			
3. Recurrent/persistent headaches or migraines?			
4. Mental illness, depression or anxiety?			
5. Disease of the heart or circulation including deep vein thrombosis, angina, or high blood pressure?			
6. Allergy to any food, drug or other substance at home or at work? Please describe the effect.			
7. Asthma, breathing disorder, lung conditions?			
Have you ever had any problems with the following?	Yes	No	If yes, please give details
8. Stomach or duodenal ulcer, indigestion,			

heartburn or stomach pains?			
9. Bowel disorder or problems?			
10. Kidney or bladder disorder, pain, blood or frequency in passing urine?			
11. Diabetes or thyroid disease?			
12. Hernia or rupture?			
13. Disorder of the bones, joints or muscles (to include hands/arms and back pain)?			
14. Skin conditions?			
15. Ear disease or deafness?			
16. Eye disorders including colour blindness? Have you had laser/corneal surgery?			
17. Hepatitis, jaundice or other liver or gall bladder disease?			
18. Disturbed sleep from snoring or breathing difficulty, daytime sleepiness, or been seen at a sleep clinic?			
19. Drug or alcohol misuse?			
20. Have you ever had a serious injury or broken bones?			
21. Have you ever had an operation?			
Have you ever had any problems with the following?	Yes	No	If yes, please give details
22. Have you ever had hospital tests or treatment?			

23. Are you taking any drugs or medicines? If yes, please list.			
24. Have you left a job for medical reasons?			
25. Have you ever had an illness caused by your work?			
26. Have you been away from work for at least two weeks due to illness in the past two years?			
27. Do you suffer from any other health problem or disability, which is relevant to your job or the proposed job?			
28. Any other health condition not mentioned above?			

Previous employment (Only complete section if this is a pre-employment examination)

From	To	Job and any known hazards

Declaration

In signing this questionnaire you confirm that all the information provided is true to the best of your knowledge. You accept that if it is subsequently shown that relevant medical information has not been disclosed or has been misleading or false: 1) in some circumstances you may reasonably be regarded as unfit to do this particular job or 2) your employer may reconsider eligibility for certain ill-health financial benefits, including sick pay or 3) your employer may consider a disciplinary investigation.

In the event of there being a work issue which may be related to your health Occupational Health and Wellbeing will confirm to your employer whether the relevant medical information was disclosed on the questionnaire.

Signature ………………………………………………………… Date ……………………………………………