

Employee Medical Questionnaire



CONFIDENTIAL

The purpose of the questionnaire is to see whether you have any health problems that could affect your ability to undertake the duties of the post you have been offered or place you at any risk in the workplace. We may recommend adjustments or assistance as a result of this assessment to enable you to do the job. Our aim is to promote and maintain the health of all people at work. Before health clearance is given for employment you may be contacted by the Healthcare Services and may need to be seen by an occupational health advisor or physician.

PERSONAL INFORMATION					
Title:	Mr	First Name:	OLATUNJI	Surname:	ADEYANJU
D.O.B	05-7-1967	Home Telephone:		Mobile:	07405447547
Work Telephone:				Email:	olatunjiadeyanju@hbmmed.co
Home Address:	13, Crooke street Barton Manchester			GP Address:	Houghton Vale Surrey TATTON ROAD, DENTON M34 7PL

MEDICAL HISTORY	
All staff groups complete this section	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have any illness/impairment/disability (physical or psychological) which may affect your work?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Have you ever had any illness/impairment/disability which may have been caused or made worse by your work?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Are you having, or waiting for treatment (including medication) or investigations at present? If your answer is yes, please provide further details of the condition, treatment and dates.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Do you think you may need any adjustments or assistance to help you to do the job	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
ADDITIONAL INFORMATION (If you have answered yes to any questions above please provide additional information below)	

Clinical diagnosis and management of tuberculosis, and measures for its prevention and control (NICE 2006)		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Have you lived continuously in the UK for the last 5 years?		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
If you answered no above, please list all of the countries that you have lived in over the last 5 years		
Have you had a BCG vaccination in relation to Tuberculosis?		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
If you answered yes please state when <u>childhood</u>		Date: <input type="text"/>
Do you have any of the following		
A cough which has lasted for more than 3 weeks	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Unexplained weight loss
Unexplained fever	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Have you had tuberculosis (TB) or been in recent contact with open TB
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
ADDITIONAL INFORMATION (If you have answered yes to any questions above please provide additional information below)		
CHICKEN POX OR SHINGLES		
Have you ever had chicken pox or shingles?		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
		Date: <input type="text"/>

IMMUNISATION HISTORY			
Have you had any of the following immunisations?		Yes <input type="checkbox"/> No <input type="checkbox"/>	Date: <input type="text"/>
Triple vaccination as a child (Diphtheria / Tetanus / Whooping cough)		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Date: <input type="text"/>
Polio		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Date: <input type="text"/>
Tetanus		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Date: <input type="text"/>
Hepatitis B (If Yes is ticked please give dates below)		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Date: <input type="text"/>
Course:	1	2	3
Boosters:	1	2	3

PROOF OF IMMUNITY (Please send the following)	
Varicella	You must provide a written statement to confirm that you have had chicken pox or shingles however we strongly advise that you provide serology test result showing varicella immunity

Tuberculosis	We require an occupational health/GP certificate of a positive scar or a record of a positive skin test result (Do not Self Declare)
Rubella, Measles & Mumps	Certificate of "two" MMR vaccinations or proof of a positive antibody for Rubella Measles & Mumps
Hepatitis B	You must provide a copy of the most recent pathology report showing titre levels of 100iu/l or above

PROOF OF IMMUNITY (Please send the following) EPP Candidates Only

Hepatitis B Surface Antigen	Evidence of a negative Surface Antigen Test Report must be an identified validated sample. (IVS)
Hepatitis C	Evidence of a negative antibody test Report must be an identified validated sample. (IVS)
HIV	Evidence of a negative antibody test Report must be an identified validated sample. (IVS)


EXPOSURE PRONE PROCEDURES

Will your role involve Exposure Prone Procedures

Yes ☐ No ☒

DECLARATION

I declare that the answers to the above questions are true and complete to the best of my knowledge and belief. I also give consent for Golden Recruitment to make recommendations to my employer.

Signed: 	Print Name: D. R. D. Y. A. N. J. Y	Date: 07/10/18
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