gipping
occupational health
and wellbeing

Gipping Occupational Health Ltd
10-11 Norfolk House, WilliamSport Way, Lion Barn Industrial Estate
Needham Market, Suffolk, IP6 8RW

Form 2: Health Questionnaire

Fields marked with * are mandatory

1. Personal Details

Paper screening ☐ Face to face assessment ☐

Surname: * Mr ☐ Mrs ☐ Ms ☐

First Name(s): *

Home Address: *

Email Address: *

Home Phone: * Work: Mob:
(please provide at least 1 contact telephone number)

Date of Birth: * (dd/mm/yy)

Doctor's Name:

Doctor's Address:

Doctor's Tel No:

New/Current Employment Details - If you are completing this form as part of a pre-employment process could you complete this section with your new employer details

Company name: * Subsidiary group:

Job title/role: * Night worker: Yes ☐ No ☐

Start date: * (dd/mm/yy)

Location: *

Line manager: *

Employment History (at least 5 years, most recent first)

Employer	Job title	How many months / years in position ?
1.		
2.		
3.		
4.		
5.		

2. Health History

Do you have or have you ever had in the past:	YES	NO	If YES, give details and dates
Conditions of the lungs? Asthma? Bronchitis? Pleurisy? Tuberculosis? Other chest complaints? Coughing up blood? Shortness of breath? Any other conditions?	☐	☐	
Conditions of the heart? Heart Attacks? Angina?	☐	☐	
High/Low blood pressure?	☐	☐	
Clots in the legs or lungs	☐	☐	
Excessive bleeding or bruising?	☐	☐	
Nervous system disorder? Blackouts? Epilepsy? Muscular weakness? Paralysis? Head injury? Concussion?	☐	☐	
Migraine or persistent headaches?	☐	☐	
Conditions of the digestive system? Irritable bowel syndrome? Liver complaints/jaundice? Colitis? Gastric/duodenal ulcer? Any other conditions?	☐	☐	
Hernia?	☐	☐	
Conditions of the kidney or bladder? Urinary infection? Kidney stones?	☐	☐	
Conditions or injuries of the bones, joints and limbs? Broken bones or fractures? Arthritis? Rheumatism? Sciatica? Shoulder problems? Upper limb disorder? Tennis elbow? Repetitive Strain problems? Any other condition?	☐	☐	
Back problems? Neck or spinal problems? Prolonged back, neck or shoulder pain?	☐	☐	
Rheumatic fever?	☐	☐	

Do you have or have you ever had in the past:	YES	NO	If YES, give details and dates
Allergies? (Including allergies to drugs, animals, bee stings and pollens).	☐	☐	
Skin conditions? Eczema? Dermatitis? Psoriasis? Recent skin Infection? Skin cancer?	☐	☐	
Gland trouble? Thyroid overactive/under active?	☐	☐	
Diabetes?	☐	☐	
Eye Conditions? Restricted vision? Glaucoma? Iritis? Any other condition?	☐	☐	
Do you wear glasses/contact lenses?	☐	☐	
Ear conditions? Restricted hearing? Tinnitus? Ear infections?	☐	☐	
Do you wear hearing aids?	☐	☐	
Cancer or other tumors?	☐	☐	
Any history of tropical or infectious diseases? Eg Malaria, TB, Hepatitis?	☐	☐	
Have you travelled abroad in the past 6 months?	☐	☐	
Mental illness and/or stress related problems? Nervous breakdown? Mental fatigue? Anxiety? Depression? Panic attacks? Significant sleep disturbance? Stress related problems? Eating disorders? Self harm? Any other conditions?	☐	☐	
Alcohol or drug problems? Problems related to alcohol or drug usage or dependency?	☐	☐	
Are you receiving medical treatment at the present time?	☐	☐	

Do you have or have you ever had in the past:	YES	NO	If YES, give details and dates
Do you take regular medication?	☐	☐	
Have you consulted your GP in the last 12 months?	☐	☐	
Have you visited a therapist e.g. physiotherapist, osteopath, chiropractor etc. in the last year?	☐	☐	
Do you expect to consult a doctor or expect to receive any treatment in the near future?	☐	☐	
Have you spent any time in hospital other than already stated?	☐	☐	
Have you ever had an X-ray, CT scan, Ultrasound scan, MRI scan?	☐	☐	
Is there any history of serious illness or disease in your family?	☐	☐	

3. Work Related Health History

Do you have or have you ever in the past:	YES	NO	If YES, give details and dates
Been absent from work or full time study due to ill health during the last 2 years (including illness such as colds etc)? If YES include:- • Number of days • Reason	☐	☐	
Left or been denied a job on health grounds?	☐	☐	
Been refused life/ disability insurance or military service for medical reasons?	☐	☐	
Been denied a driving license on health grounds?	☐	☐	

Do you have or have you ever in the past:	YES	NO	If YES, give details and dates
Had any disease or injury arising out of your work eg deafness, backache, dermatitis, asthma, vibration white finger or any other work related health conditions?	☐	☐	
Worked in a dusty environment?	☐	☐	
Worked in a noisy environment?	☐	☐	
Was hearing protection used during this time?	☐	☐	
Worked with chemicals?	☐	☐	
Did you suffer or experience any health problems associated with these chemicals?	☐	☐	
Worked with x-rays or other forms of radiation?	☐	☐	
Worked with vibrating tools?	☐	☐	
Have you ever been advised for medical reasons not to do night work, shift work, or any other kind of work?	☐	☐	
Is there any reason why you cannot wear Personal Protective Equipment (PPE)?	☐	☐	
Is there any other condition that may impact on your ability to safely perform the duties of your job?	☐	☐	
Worked with asbestos, lead, biological substance or any respiratory or skin hazard?	☐	☐	
Undergone health surveillance due to hazards in your job?	☐	☐	

4. Social History

	YES	NO	
Do you drink alcohol?	☐	☐	If YES, how many standard drinks in 1 week and what type of alcohol?

Have you ever felt you should cut down your drinking? YES ☐ NO ☐

Have people annoyed you by criticizing your drinking? YES ☐ NO ☐

Have you ever felt bad or guilty about your drinking? YES ☐ NO ☐

	YES	NO		
Do you currently smoke?	☐	☐	If YES, how many cigarettes in 1 day?	How many years have you smoked?
Have you ever smoked?	☐	☐	If YES, how many cigarettes in 1 day?	How long ago did you quit?
Do you use any recreational drugs?	☐	☐	If YES, what types?	How often?
Do you engage in regular exercise?	☐	☐	If YES, what types?	How often?
Do you bite your fingernails?	☐	☐	Are you right or Left hand dominant?	Right ☐ Left ☐

5. Physical Details

Do you have difficulties with the following activities	YES	NO	Do you have difficulties with the following activities	YES	NO
Running 50 metres	☐	☐	Walking on rough or uneven ground	☐	☐
Kneeling or crouching	☐	☐	Standing or sitting for 2 hours or more	☐	☐
Climbing stairs or ladders	☐	☐	Lifting or bending	☐	☐
Using hand tools	☐	☐	Gripping firmly with both hands	☐	☐
Repetitive movement of hands or arms	☐	☐	Confined spaces or working at heights	☐	☐
Working in extremes of temperature	☐	☐	Shift work	☐	☐

Do you have difficulties with the following activities	YES	NO	Do you have difficulties with the following activities	YES	NO
Concentrating on what you are doing	☐	☐	Turning your head rapidly	☐	☐
Reading ordinary print	☐	☐	Understanding English including reading signs	☐	☐
Hearing a normal conversation	☐	☐			

Vaccination History

Have you had the following Immunizations?	Yes	No	Date	Have you had the following Immunizations?	Yes	No	Date
Tetanus	☐	☐	(dd/mm/yy)	Hepatitis B	☐	☐	(dd/mm/yy)
Hepatitis A	☐	☐	(dd/mm/yy)	Other vaccinations	☐	☐	(dd/mm/yy)

Declaration and Authority to Release Information

- The Health and Safety at Work Act 1974, requires employers to ensure, so far as is reasonably practicable, your health, safety and welfare while at work. To help us to help you and your employer, we are asking you to complete this form before attending for your health assessment. **Please bring it with you to your first appointment. This will form the front cover of your confidential Occupational Health Records.**
- At the health assessment you will be asked further questions about your health and your work. Medical information is held in **Confidence** by the Occupational Health Service and is not passed on without your specific written consent.
- The use of personal sensitive information is regulated in law by the General Data Protection Regulations (GDPR) and covered by the ethical requirements of the General Medical Council/Nursing & Midwifery Council. A copy of our Privacy Notice which relates to how we handle your personal sensitive information is available on request.
- Any information requested from a treating Doctor is in accordance with the Access to Medical Reports Act 1988 and the General Data Protection Regulations.
- Any information supplied to your employer is about your ability to work safely and without detriment to your health.

Declaration:

- I declare that each and every answer above is true to the best of my knowledge and belief and I consent to a physical assessment

Statement Authorisation:

- By submitting the completed questionnaire you hereby authorise the examining Occupational Health Advisor to submit a report to my employer regarding your fitness for the role

Signature * **Date:**

Print name: _____ _____

dd/mm/yy

CLICK HERE TO SUBMIT COMPLETED FORM

GOH USE ONLY
Additional Information

Clinical Summary Fitness Statement issued based on: PAPER SCREENING ☐ FACE TO FACE ☐

OH Advisor Name Date:

Signature: