

Occupational Health Questionnaire

In order for you to be accepted onto your applied programme, you are required to complete a Health Questionnaire. This information can be complemented by a request for additional information from your General Practitioner (GP). Our main purpose is to identify what support you might require on your course.

We are mindful of supporting candidates with health conditions and disabilities so if a health concern is identified this does not mean that the offer of the placement is withdrawn, it simply means we need to explore if you will require further support on your course. We may ask you to attend for a further health assessment or provide additional medical information in order that we can identify what adjustments you may require in order for you to undertake your course.

To submit this questionnaire, please either send it to the address below or alternatively email it to **occupationalhealth@newhamhealth.nhs.uk** or fax it to 0207 363 8643.

If you would like to discuss any aspect of this questionnaire in confidence, please email occupationalhealth@newhamhealth.nhs.uk or call 0207 363 8677.

The completed questionnaire should be returned to:

**Occupational Health and Wellbeing department
Newham University Hospital
Glen Road
Plaistow
London
E13 8SL**

PLEASE NOTE THAT ALL COMMUNICATION FROM THE OCCUPATIONAL HEALTH SERVICE WILL BE ELECTRONIC, SO PLEASE ENSURE YOU CHECK YOUR EMAILS DAILY ONCE YOU HAVE SUBMITTED YOUR FORM UNTIL THEY HAVE ADVISED YOU THAT THEY HAVE SATISFACTORILY PROCESSED YOUR FORM. ONLY SUBMIT YOUR EMAIL ADDRESS IF YOU WILL CHECK THIS REGULARLY.

Personal Details

Dr/Mr/Mrs/Miss/Other:

Male/Female:

Surname:

First Name:

Date of birth:

Address:

Email address:

PLEASE STATE IF YOU DO NOT HAVE ACCESS TO EMAIL

Home Telephone No:

Mobile:

Programme applied for:

Starting date:

TO COMPLETE THIS ELECTRONICALLY DOUBLE CLICK ON THE GREY BOX AND INDICATE 'CHECKED'. THIS WILL ADD A CROSS INTO THE BOX

Do you consider yourself to have a disability? A disability can be considered a mental or physical condition, which affects your normal activities of daily living. YES ☐ NO ☐

If yes what is your disability?:

Do you believe you require any adjustments/modifications to assist you undertaking this course?

YES ☐ NO ☐ Please state below what adjustments/modifications you think you may require?

Have you contacted the University of East London **Disability and Dyslexia Service**? YES ☐ NO ☐
If not, please ring 020 8223 7306 or email ddu@uel.ac.uk

Would you like us to contact them and advise them of your details and your disability? YES ☐ NO ☐

IMPORTANT Please note the following:

You must let us know at this point of any health problems you have or had in the past, so that we can make the appropriate adjustments to support you on your course.

We will advise the University any adjustments/modifications we believe you require to undertake the course. We will discuss these with you before we notify the University to ensure we have your consent to release this information. There are times when we may need the University to be aware of your condition but again we will discuss this with you and obtain your consent before we release any information.

By sending this completed form you are stating that the answers to all the questions asked are true and complete to the best of your knowledge and belief and that you understand that making false statements or failure to declare a health problem could lead to your place on the course being withdrawn at any stage of your course.

Medical History:

PLEASE ANSWER ALL THE FOLLOWING QUESTIONS BY 'checking' 'YES' OR 'NO' AS APPROPRIATE. IF YOU ANSWER YES, PLEASE GIVE FURTHER DETAILS

How many days have you been away from work or study because of ill health in the last 3 years? Please give cause and approximate dates:

Do you have any skin conditions which have an impact on you on a regular basis e.g. eczema, dermatitis, psoriasis or other? (Please do not declare if these are mild)

YES ☐ NO ☐ Details:

Have you been treated by a doctor or other health professional in the past three months?

YES ☐ NO ☐ Details:

Are you awaiting a hospital/specialist appointment or any investigation?

YES ☐ NO ☐ Details:

Have you ever had depression, anxiety or any other psychological or psychiatric condition?

YES ☐ NO ☐ Details:

Do you suffer from epilepsy, fits, blackouts or frequent faints?

YES ☐ NO ☐ Details:

Do you suffer from frequent headaches or migraine?

YES ☐ NO ☐ Details:

Are you taking pills, tablets or medicines at the moment (excluding contraception)?

YES ☐ NO ☐ Details:

Do you have diabetes, which is not well-controlled?

YES ☐ NO ☐ Details:

Do you have varicose veins, which causes difficulty with standing?

YES ☐ NO ☐ Details:

Have you had, or do you presently have, a condition affecting your musculo-skeletal system (limbs, joints, back, neck, shoulder, arm or wrists etc.), including arthritis or limb deformities?

YES ☐ NO ☐ Details:

Do you have hearing loss, which is not corrected by a hearing aid?

YES ☐ NO ☐ Details:

Do you have an eyesight problem, which is not corrected by glasses/contact lenses?

YES ☐ NO ☐ Details:

Have you had unexplained weight loss, fevers, a persistent cough, loss of appetite, lethargy or night sweats in the last six months?

YES ☐ NO ☐ Details:

Have you ever had tuberculosis (TB)?

YES ☐ NO ☐ Details:

Do you suffer from frequent diarrhoea or other bowel disorders (IBS, celiac, etc)?

YES ☐ NO ☐ Details:

Have you ever had an alcohol or drug problem?

YES ☐ NO ☐ Details:

Do you drink alcohol?

NO ☐ YES ☐ (please state amount per week) Details:

Have you ever been treated for weight gain or loss?

YES ☐ NO ☐ Details:

Do you have any other health problem not mentioned above?

YES ☐ NO ☐ Details:

For Occupational Health use only

Date Health Cleared:

Cleared by:

Date: