# SHG Coat of Arms (With Lettering)

# CONFIDENTIAL

# PRE-EMPLOYMENT MEDICAL QUESTIONNAIRE

(Applied for healthcare positions)

**Guidance notes**

The purpose of the Pre-employment Health Questionnaire is to provide information about your medical history which will assist in the following ways:

* to ensure that you are medically suitable for the proposed job;
* to advise, where necessary, on any reasonable adjustments to your work or workplace to suit you, so that any underlying health problem is not made worse by work
* to ensure that you do not have a medical condition which could pose a risk to your safety or to that of your colleagues, residents or members of the public.
* to help us identify if there is a risk of developing a work related illness from any hazards in the proposed workplace.

Pre-employment Screening takes into account both current and previous health factors.

The medical data on this form will remain **confidential**. The medical contents of this form will not be disclosed to anyone without your explicit or written consent.

One form will need to be completed per person; yourself as the candidate and any accompanying dependants.

Section 1 will need to be completed by you/your dependant, an appointment with your General Practitioner will need to be made for the completion of section 2. Please ensure you answer all the questions. Failure to fully complete this questionnaire will result in a delay to your health clearance and subsequent start date.

On completion of the form by your General Practitioner, together with any supporting documentation (e.g. blood test results), please send directly to the St Helena Government United Kingdom Representative on the following email address: shgukrep@sthelenagov.com

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| **SECTON 1** | | **To be completed by candidate and accompanying dependants** | | | | | | | | | | |
|  | |  | | | | | | | | | | |
| **PERSONAL** | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| Surname | |  | | | | Name | | | |  | | |
| Other Names | |  | | | | Date of Birth | | | |  | | |
| Age | |  | | | | Sex | | | |  | | |
| Martial Status | |  | | | | | | | | | | |
| I am the candidate | | | |  | | I am a dependant of the candidate | | | | | |  |
| Position Applied For | |  | | | | | | | | | | |
| Address | |  | | | | | | | | | | |
| Home Telephone | |  | | | | Work Telephone | | |  | | | |
| Mobile Number | |  | | | | Email Address | | |  | | | |
|  | |  | | | |  | | |  | | | |
| Name of Family Doctor | | | |  | | | | | | | | |
| Address of Family Doctor | | | |  | | | | | | | | |
| Vaccination status (as appropriate) | | | | | | | | | | | | |
| Typhoid |  | | Meningitis | | |  | | Hepatitis B | | |  | |
| Polio |  | | Hepatitis A | | |  | | Cholera | | |  | |
| Tetanus |  | |  | | | | | | | | | |
| In which countries have you lived | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| Have you ever in your life, including childhood, had any of the following | | | | | | | | | | | | |
|  | | | Yes | | No | | If Yes, please provide details if necessary | | | | | |
| Fainting attacks or giddiness | | |  | |  | |  | | | | | |
| Blackouts, epilepsy or fit | | |  | |  | |  | | | | | |
| Bronchitis, asthma or Pneumonia | | |  | |  | |  | | | | | |
| Dermatitis or other skin Disorders | | |  | |  | |  | | | | | |
| Heart trouble, heart attack or angina | | |  | |  | |  | | | | | |
| Nervous disorder, depression or break down | | |  | |  | |  | | | | | |
| Recurring headaches or migraine | | |  | |  | |  | | | | | |
| Back, neck or any Joint or skeletal problems | | |  | |  | |  | | | | | |
| Tuberculosis | | |  | |  | |  | | | | | |
| Bowel Disorders | | |  | |  | |  | | | | | |
| Diabetes | | |  | |  | |  | | | | | |
| Recurrent indigestion/Dyspepsia | | |  | |  | |  | | | | | |
| Rupture/hernia | | |  | |  | |  | | | | | |
| Varicose veins | | |  | |  | |  | | | | | |
| Severe shortness of breath | | |  | |  | |  | | | | | |
| Raised blood pressure | | |  | |  | |  | | | | | |
| Sinusitis, discharging ears or hearing difficulties | | |  | |  | |  | | | | | |
| Serious accident or injury | | |  | |  | |  | | | | | |
| Any operations- | | |  | |  | |  | | | | | |
| List of any chronic (regular) medication: | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| List of current medication: | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| What is your average consumption of alcohol per week (units)? | | | | | | | | | | | | |
|  | | | | | | | | | | | | |

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| **DECLARATION: I declare that to the best of my knowledge all the foregoing statements are correct and give authorisation for a medical examination to be carried out.** | | | |
| **Signed** |  | **Date** |  |

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| --- | --- |
| **SECTON 2** | **To be completed by examining doctor** |

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| **MEDICAL EXAMINATION** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **General** | | | | | | | | | | | | | | |
| Weight |  | | | | | Skin | | | | | | |  | |
| Height |  | | | | | Teeth/Gums | | | | | | |  | |
| General appearance |  | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | |
| **Cardiovascular System** | | | | | | | | | | | | | | |
| Pulse | |  | | | | Peripheral circulation | | | | | |  | | |
| BP | |  | | | | Varicose Veins | | | | | |  | | |
| ECG (if indicated) | |  | | | | | | | | | | | | |
| Result | |  | | | | | | | | | | | | |
| Auscultation of Heart: | |  | | | | | | | | | | | | |
|  | |  | | | | | | | | | | | | |
| **Respiratory System** | | | | | | | | | | | | | | |
| Shape of Chest: | |  | | | | Chest X-ray if indicated: | | | | | |  | | |
| Results | |  | | | | | | | | | | | | |
| Expansion: | |  | | | | | Breath Sounds: | | | | |  | | |
| Result | |  | | | | | | | | | | | | |
| Lung function test if indicated | |  | | | | | | | | | | | | |
| Result | |  | | | | | | | | | | | | |
| Peak Expiratory Flow | |  | | | | | | | | | | | | |
|  | |  | | | | | | | | | | | | |
| **GIT/GUT** | | | | | | | | | | | | | | |
| General Conditions | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| Hernia | | |  | | | | | | | | | | | |
| Urinalysis | | | Protein |  | Glucose | | | | |  | Others | | |  |
|  | | |  |  |  | | | | |  |  | | |  |
| **C.N.S** | | | | | | | | | | | | | | |
| General | |  | | | | | Mental State: | | | | |  | | |
| Reflexes | |  | | | | | Cranial Nerves | | | | |  | | |
| Eyesight: (R)…. (L) | |  | | | | | Colour Vision: | | | | |  | | |
| Visual Fields: Fundi: | |  | | | | |  | | | | |  | | |
|  | |  | | | | |  | | | | |  | | |
| **ENT** | | | | | | | | | | | | | | |
| Ears: | |  | | | | | Nose: | | | | |  | | |
| Hearing; | |  | | | | | Throat: | | | | |  | | |
| Audiometry if indicated: | |  | | | | | | | | | | | | |
|  | |  | | | | | | | | | | | | |
| **MUSCULO-SCELETAL** | | | | | | | | | | | | | | |
| Muscle strength, joint movements and gait normal | | | | | | | | J/N | | | | | | |
| Any signs of Gout, Arthritis or spinal disorder | | | | | | | | J/N | | | | | | |
| Comments | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| Biochemistry profile Renal: Na, K, Urea, Creatinine | | | | | | | | |  | | | | | |
| Liver: ALP, ALT, Bil, TP, ALB | | | | | | | | |  | | | | | |
| Fasting Cholesterol | | | | | | | | |  | | | | | |
| Fasting Glucose | | | | | | | | |  | | | | | |
| Within normal limits J/N | | | | | | | | |  | | | | | |
| Abnormalities | | | | | | | | |  | | | | | |
| Haematology profile: FBC, ESR, Diff WCC | | | | | | | | |  | | | | | |
| Chest X-ray | | | | | | | | |  | | | | | |
| Mandatory Blood Test | | | | | | | | |  | | | | | |
| General state of health – excellent/fair/poor | | | | | | | | |  | | | | | |
|  | | | | | | | | |  | | | | | |
| **OTHER REQUIRED TESTS** | | | | | | | | | | | | | | |
| TB | | | | | | | | |  | | | | | |
| Hepatitis B | | | | | | | | |  | | | | | |
| Hepatitis C | | | | | | | | |  | | | | | |
| HIV | | | | | | | | |  | | | | | |
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| **I certify that I have examined the above-named and have found him/her to be both mentally fit/unfit and physically fit/unfit.** | | | |
| **SIGNED** |  | **DATED** |  |
| **DOCTOR’S NAME**  **(In block capitals)** |  | **Registration Number** |  |

**THE ST HELENA GOVERNMENT WOULD BE GRATEFUL IF THIS FORM COULD BE STAMPED WITH THE RELEVANT STAMP USED IN THE MEDICAL PRACTICE**