Work Experience - Medical Questionnaire

Practice Name:	
Surname:	
Forenames:	
Date Of Birth:	
School/College Address:	
Contact Person:	
Contact Number:	
Home Address:	
Next Of Kin: **Relationship:**	
Contact Number:	
Name Of Doctor:	
Address Of Doctor:	
Contact Number Of Doctor:	

Please answer all the following questions by ticking the appropriate box and providing additional information where relevant:

	Questions	YES	NO
1	Do you have any physical or mental impairment that could be classed as a disability under the Equality Act 2010?		
Comments:			
2	Are you able to carry out strenuous physical work including climbing ladders, bending, lifting and carrying?		
Comments:			
3	Have you ever had any operations requiring hospital admission for five or more days?		
	Has this hospital admission been within the last 6 months?		
Comments:			
4	Have you consulted a doctor about your health during the past 12 months?		
Comments:			
5	Do you have any diagnosed long-term health conditions? Such as diabetes, epilepsy etc.		
Comments:			
6	Do you take any prescribed medication? If so, what do you take / how much / how often?		
Comments:			

	Questions	YES	NO
7	Have you ever had any of the following?		
	Tuberculosis		
	Bronchitis,		
	Pneumonia		
	Asthma		
	Any other respiratory problems?		
Comments:			
8	Have you ever had any of the following?		
	Angina		
	Raised blood pressure		
	Any other cardio/circulatory problems?		
Comments:			
9	Have you ever had any of the following?		
	Peptic, gastric or duodenal ulcer		
	Indigestion for more than one week		
	Kidney trouble or urinary infection		
	Any other gastrointestinal problems?		
Comments:			
	Questions	**YES**	**NO**

10	Have you ever had any of the following?		
	Lumbago or any other back pain		
	Sciatica or any other nerve problems		
	Damage to an intervertebral disc		
	Strain or any other damage to muscles		
	Sprain or any other damage to ligaments		
	Any other musculoskeletal problems?		
Comments:			
11	Have you ever had any of the following?		
	Recurring fainting or giddiness		
	Recurring blackout		
	Recurring seizures		
	Migraines		
	Severe recurring headaches		
	Any other vasovagal problems?		
Comments:			
	Questions	**YES**	**NO**

12	Have you ever had any of the following?		
	Anxiety, depression		
	Any other nervous or emotional condition?		
Comments:			
13	Have you ever had any of the following?		
	Recurring discharge or infection of the ear		
	Any difficulties in hearing		
	Any other auditory problems?		
Comments:			
14	Have you ever had any of the following?		
	Do you have any allergies?		
	Do you carry any medication / epi-pens?		
Comments:			
15	Have you ever had any other serious health conditions or illness?		
Comments:			
	Questions	**YES**	**NO**
16	Is there any other information that you feel we should be aware of?		

Comments:

I declare that the information given on this form is to the best of my knowledge complete and correct

Work Experience Signature:		**Date:**	
Parent or Guardian Signature: (if under 18)		**Date:**	
Practice Line-Manager Signature:		**Date:**	

Data Protection

Information from this application is for the purposes of maintaining relevant health and contact records for you whilst you are on placement within the practice and the assessment of any health & safety risk.

This form will be destroyed once placement has completed.

Each placement will require the completion of a form.

THIS FORM MUST BE COMPLETED BEFORE COMMENCEMENT OF PLACEMENT OTHERWISE THE PLACEMENT OPPORTUNITY WILL BE CANCELLED.