BUSY BEES CARE LTD

## Candidate Health Questionnaire

Please complete the questionnaire as accurately as possible ensuring that all of the questions are answered.

The information in this questionnaire will be used to assess your medical capability for the role and if any reasonable adjustments (as defined under the Equality Act 2010) are required on taking up employment with Busy Bees Care Ltd.

Once completed, please return it to:
Busy Bees Care Ltd, Bonnington Bond, 2/4 Anderson Place, Edinburgh EN6 5NP.

### Section 1 – Post Details

Service: _____ Location: _____ NI Number: _____

Job Title: _____ Proposed Start Date: _____

### Section 2 – Personal Details

First Name: _____ Surname: _____

Date of Birth: _____ Sex (M/F): _____

Address: _____ Family Doctor: _____

_____ Address: _____

_____ _____

Contact Phone No: _____ Telephone: _____

### Section 3 – Job History

Please list your two most recent jobs and employers

| Job Title | Employer | From | To |
|---|---|---|---|
| | | | |
| | | | |

Have you been exposed to any of the following hazards in **any** previous job? If so, did you wear personal protection such as gloves or masks?

| | Exposed to Hazard | | Over what period of time | Personal protection worn? | |
|---|---|---|---|---|---|
| | **Yes** | **No** | | **Yes** | **No** |
| Display Screen Equipment (DSE Work) | ☐ | ☐ | _____ | ☐ | ☐ |
| Noise | ☐ | ☐ | _____ | ☐ | ☐ |
| Vibration | ☐ | ☐ | _____ | ☐ | ☐ |
| Asbestos | ☐ | ☐ | _____ | ☐ | ☐ |
| Chemicals | ☐ | ☐ | _____ | ☐ | ☐ |
| Physically Demanding Work | ☐ | ☐ | _____ | ☐ | ☐ |

### Section 4 – Personal History

| | **Yes** | **No** | Please give details where appropriate |
|---|---|---|---|
| Do you consider yourself to be in good health? | ☐ | ☐ | _____ |
| Do you consider yourself to be disabled? | ☐ | ☐ | _____ |
| Are you restricted for medical reasons from carrying out any particular type of work? | ☐ | ☐ | _____ |

| | | | |
|---|---|---|---|
| Have you had an illness or accident in the last three years which has caused you to be in hospital? | ☐ | ☐ | |
| Have you been in employment at all during the last 12 months? | ☐ | ☐ | |
| Have you had to give up a job for medical reasons? | ☐ | ☐ | |
| Do you take any form of regular physical exercise? | ☐ | ☐ | |
| Are you currently taking any prescribed medication on a regular basis (excluding contraceptive pills)? | ☐ | ☐ | |
| Have you consulted your own doctor or any other health practitioner (including physiotherapist, osteopath etc) during the last 3 months? | ☐ | ☐ | |

Please detail periods of sickness/absence over the last two years:

From _____ To _____ Reason _____

From _____ To _____ Reason _____

From _____ To _____ Reason _____

From _____ To _____ Reason _____

From _____ To _____ Reason _____

From _____ To _____ Reason _____

## Section 5 – Smoking and Alcohol

| | Yes | No | Please give details where appropriate |
|---|---|---|---|
| Do you smoke? | ☐ | ☐ | |
| If yes, quantity per day? | | | |
| Do you drink alcohol? | ☐ | ☐ | |
| If yes, quantity per day in units? | | | |

## Section 6 – Medical History

| | Yes | No | Please give details where appropriate |
|---|---|---|---|
| Have you had any heart trouble e.g. heart attack, angina? | ☐ | ☐ | |
| Have you been diagnosed as having high blood pressure? | ☐ | ☐ | |
| Have you had migraine attacks? | ☐ | ☐ | |
| Have you had a chest disease at any time e.g. asthma, bronchitis, pleurisy, tuberculosis? | ☐ | ☐ | |
| Do you have any allergies or allergic conditions e.g. hay fever, allergy to animals? | ☐ | ☐ | |
| Have you had recurrent indigestion, gastric or duodenal ulcer? | ☐ | ☐ | |
| Do you have recurrent diarrhoea or any chronic bowel disease? | ☐ | ☐ | |
| Have you had jaundice? | ☐ | ☐ | |

**Private and Confidential**

| | | | |
|---|---|---|---|
| Do you have, or have you had a hernia (rupture)? | ☐ | ☐ | |
| Have you had any kidney or bladder trouble? | ☐ | ☐ | |
| Do you have diabetes? | ☐ | ☐ | |
| Have you had persistent or recurrent low back pain? | ☐ | ☐ | |
| Have you had persistent or recurrent neck/shoulder pain? | ☐ | ☐ | |
| Have you had persistent or recurrent pain in the arms/hands/wrists? | ☐ | ☐ | |
| Have you had fainting attacks or blackouts? | ☐ | ☐ | |
| Have you been diagnosed as having epilepsy? | ☐ | ☐ | |
| Have you received treatment for anxiety/depression or other mental health disorder? | ☐ | ☐ | |
| Have you had treatment or support from a psychiatrist, psychologist or counsellor? | ☐ | ☐ | |
| Have you had any skin trouble, e.g. eczema, dermatitis, psoriasis or skin allergy? | ☐ | ☐ | |
| Do you have any difficulty with colour perception? | ☐ | ☐ | |
| Have you any persistent disorder/disease affecting the eyes? | ☐ | ☐ | |
| Do you wear spectacles or contact lenses? | ☐ | ☐ | |
| Have you had any ear disease or persistent discharge from either ear? | ☐ | ☐ | |
| Do you have any hearing deficiency? | ☐ | ☐ | |
| Have you had any operation? | ☐ | ☐ | |
| Do you have dyslexia, reading or writing difficulties? | ☐ | ☐ | |
| Do you have, or have you had any other medical condition not mentioned above? | ☐ | ☐ | |

Signed: _____ Date: _____