

TRANSFeree

**MEDICAL HISTORY
QUESTIONNAIRE**

CONFIDENTIAL (WHEN COMPLETED)

**COULD YOU?
POLICE**

MEDICAL HISTORY QUESTIONNAIRE

For official use only
Candidate number

CONFIDENTIAL (WHEN COMPLETED)

Our health standard requires you to show that you can give regular and effective service. In order to do this, we ask you to provide details of your health. Do not be concerned if you find yourself answering 'Yes' to a lot of questions. This is quite normal and does not mean that you are unfit for the job. We will contact you if we need further details and, if necessary, ask for a report from your GP. The health of each candidate is considered individually and no decision to reject a candidate is made without referral to a medical advisor.

Please complete this form and take it to your GP for confirmation. Once your GP has signed the form, send it to the Recruiting Department, FAO Rachel MURPHY in the envelope supplied. If no medical envelope is supplied please seal the forms in a separate, clearly marked envelope. **Please keep a copy of your form.**

You will then be invited to attend a medical examination or referred to your GP for a medical examination.

The information given on this form and at subsequent medical examinations will also be used to form an opinion of whether you are at risk of early ill-health retirement. If you do not wish to know the outcome of that assessment you can ask for it to be withheld unless you subsequently decide to appeal against the decision.

Please note that you will be required to sign a declaration at the end of this form and it is important that your answers are accurate and you do not withhold any information. We are an equal opportunities employer and recruit on the basis of ability not perceived disability. Any information given on your medical history on any disability will assist us in assessing whether reasonable adjustments can be made.

Your details	
Surname:	Forename(s):
Date of birth:	Male / female (delete as appropriate):
Full postal address including postcode:	
Telephone:	

General Practitioner's Details	
Name:	Telephone Number:
Full postal address including postcode:	

Please answer ALL the following questions. If you answer YES to any of the conditions, you will need to give details on page 5 including the appropriate medical condition number. If you have any questions, contact your local recruitment office for advice or for referral to the Occupational Health Unit.

The Disability Discrimination Act 1995 defines a person with a disability as “A physical or mental impairment which has a substantial adverse long term effect on his or her ability to carry out normal day to day activities.”

Do you have a disability which may affect your ability to undertake the role of police constable or which requires special arrangements? **Yes** **No**

If yes, what facilities/adjustments/equipment might enable you to perform the role?

Medical Conditions			
You are asked to indicate whether you currently have or have ever had any of the following medical conditions.			
1	Epilepsy, fits, blackouts, fainting turns or unexplained loss of consciousness	Yes	<input type="checkbox"/> No <input type="checkbox"/>
2	Head injuries leading to loss of consciousness requiring hospital admission	Yes	<input type="checkbox"/> No <input type="checkbox"/>
3	Recurrent headache or migraine	Yes	<input type="checkbox"/> No <input type="checkbox"/>
4	Diseases of the nervous system e.g. neuritis, stroke, multiple sclerosis	Yes	<input type="checkbox"/> No <input type="checkbox"/>
5	Injury or surgery to your eye(s) including laser eye surgery or any other type of refractive surgery	Yes	<input type="checkbox"/> No <input type="checkbox"/>
6	Any visual defect e.g. scotoma, blindness in one eye, night blindness, colour blindness, reduced visual field, blurred vision or detached retina	Yes	<input type="checkbox"/> No <input type="checkbox"/>
7	Any eye disease or conditions such as glaucoma or retinitis pigmentosa	Yes	<input type="checkbox"/> No <input type="checkbox"/>
8	Ear infection, discharge, tinnitus, a hearing defect including deafness	Yes	<input type="checkbox"/> No <input type="checkbox"/>
9	Vertigo, dizziness, giddiness, problems with balance	Yes	<input type="checkbox"/> No <input type="checkbox"/>
10	Chest pain, angina, heart disease or breathlessness	Yes	<input type="checkbox"/> No <input type="checkbox"/>
11	Varicose veins or circulation problems	Yes	<input type="checkbox"/> No <input type="checkbox"/>
12	Rheumatic fever	Yes	<input type="checkbox"/> No <input type="checkbox"/>
13	Raised or low blood pressure	Yes	<input type="checkbox"/> No <input type="checkbox"/>
14	Any blood disorder	Yes	<input type="checkbox"/> No <input type="checkbox"/>
15	Asthma, bronchitis, emphysema, pleurisy, pneumonia or any other lung disease including TB or pneumothorax disorder	Yes	<input type="checkbox"/> No <input type="checkbox"/>
16	Recurrent nausea, dyspepsia, heartburn, indigestion or hiatus hernia	Yes	<input type="checkbox"/> No <input type="checkbox"/>
17	Gastric, duodenal or peptic ulcer	Yes	<input type="checkbox"/> No <input type="checkbox"/>
18	Inflammation of the bowel including Crohn's Disease, ulcerative colitis, bleeding from rectum or diarrhoea lasting more than one week	Yes	<input type="checkbox"/> No <input type="checkbox"/>
19	Irritable bowel syndrome	Yes	<input type="checkbox"/> No <input type="checkbox"/>

Medical Conditions			
20	Jaundice or any form of hepatitis or other liver problem	Yes	<input type="checkbox"/> No <input type="checkbox"/>
21	Any other abdominal complaint including hernia	Yes	<input type="checkbox"/> No <input type="checkbox"/>
22	Kidney stones	Yes	<input type="checkbox"/> No <input type="checkbox"/>
23	Recurrent kidney or urinary tract infection e.g. cystitis and urethritis	Yes	<input type="checkbox"/> No <input type="checkbox"/>
24	Blood in urine	Yes	<input type="checkbox"/> No <input type="checkbox"/>
25	Any other kidney or bladder conditions	Yes	<input type="checkbox"/> No <input type="checkbox"/>
26	Any problems with bones or joints including back, neck, knee, sciatica, any fracture, or recurrent dislocation of a major joint	Yes	<input type="checkbox"/> No <input type="checkbox"/>
27	Have you ever consulted an orthopaedic surgeon, chiropractor, osteopath or physiotherapist?	Yes	<input type="checkbox"/> No <input type="checkbox"/>
28	Have you been diagnosed as having arthritis, gout, chondromalacia patellae or rheumatism?	Yes	<input type="checkbox"/> No <input type="checkbox"/>
29	Psoriasis, eczema, allergic skin rash or other skin disease	Yes	<input type="checkbox"/> No <input type="checkbox"/>
30	Any metabolic disorder including diabetes, thyroid and adrenal gland disease or other glandular disorder	Yes	<input type="checkbox"/> No <input type="checkbox"/>
31	Any disorders of reproductive organs including gynaecological, testicular and breast problems	Yes	<input type="checkbox"/> No <input type="checkbox"/>
32	Any infectious diseases (apart from childhood illnesses) including sexually transmitted disease or tropical disease	Yes	<input type="checkbox"/> No <input type="checkbox"/>
33	Anxiety/depression, phobias, mental breakdown or stress related problems	Yes	<input type="checkbox"/> No <input type="checkbox"/>
34	Any other mental illness	Yes	<input type="checkbox"/> No <input type="checkbox"/>
35	Any eating disorder e.g. anorexia nervosa or bulimia	Yes	<input type="checkbox"/> No <input type="checkbox"/>
36	Substance misuse (e.g. drugs, steroids)	Yes	<input type="checkbox"/> No <input type="checkbox"/>
37	Any allergies including hayfever	Yes	<input type="checkbox"/> No <input type="checkbox"/>
38	Any operations or surgical procedures	Yes	<input type="checkbox"/> No <input type="checkbox"/>
39	Any malignancies or cancers	Yes	<input type="checkbox"/> No <input type="checkbox"/>
40	Any unexplained weight loss in past year	Yes	<input type="checkbox"/> No <input type="checkbox"/>
41	Current treatment. Are you currently attending a hospital/GP for treatment or waiting for an appointment?	Yes	<input type="checkbox"/> No <input type="checkbox"/>
<p>If you have ticked 'Yes' to any of the above, please give details in the space provided on page 5. This will help the Occupational Health Unit to clarify the significance or otherwise of a 'Yes' answer. Please ensure that you quote the correct medical condition number.</p>			

Details of Medical Conditions

Please include date(s) of illness/conditions, frequency, duration, what treatment was given and by whom (e.g. hospital/GP), whether you are still undergoing treatment and length of absence from work/school (if appropriate). Continue on a separate sheet if required.

Medical Condition Number (see table on pages 3 and 4)	Details

Family History

Is there a family history of a congenital condition (e.g. heart disease, strokes, nervous or mental disease)? If YES please give details and relationship

Height (metres)	Weight (kgs)

Alcohol History

How much alcohol on average do you consume over a seven day period?
Units per week 1 unit = 1/2 pint beer = 1 glass of wine = 1 measure of spirits

Past Medical History

Have you ever failed a medical examination (or had special conditions imposed) for any employment reasons (including police service and HM Forces) or life assurance? If YES, please provide details.

Yes No

Have you previously been notified that you would not be eligible for ill health benefits if appointed to the police service? If YES, please provide details.

Yes No

Have you ever left a job or had to be medically retired due to ill health? If YES, please provide details.

Yes No

Has any previous occupation caused you health problems? If YES, please provide details.

Yes No

Are you in receipt of a medical pension or other disability benefit? If YES, please provide details.

Yes No

General Practitioner's Comments			
Please note that a medical examination is not required.			
Are you in possession of this patient's complete medical history?	Yes	<input type="checkbox"/>	No <input type="checkbox"/>
From the medical records available, is there any medical reason why your patient should not undertake strenuous physical exercise?	Yes	<input type="checkbox"/>	No <input type="checkbox"/>
According to these records and your knowledge of the applicant, do the answers given by him/her in the questionnaire appear correct?	Yes	<input type="checkbox"/>	No <input type="checkbox"/>
Are you aware of any other medical information which might be relevant to this application?	Yes	<input type="checkbox"/>	No <input type="checkbox"/>
If so, please give details.			
General Practitioner's signature		Date	Practice Stamp
Please note: any fee required for the completion of this form will be paid by the applicant. A medical examination is not required.			