Health questionnaire

To be completed by all applicants

Name: ..... Date of birth: .....

Address: ..... Position applied for: .....
.....
.....

Next of kin: .....

Do you have or have ever suffered from

1)	Fainting attacks	yes / no	17)	Back trouble	yes / no
2)	Fits / blackouts	yes / no	18)	Muscle or joint trouble	yes / no
3)	Recurring headaches / migraines	yes / no	19)	Skin trouble	yes / no
4)	Earache or deafness	yes / no	20)	Diabetes	yes / no
5)	Giddiness	yes / no		If so are you insulin dependent	yes / no
6)	Eye trouble or poor vision	yes / no	21)	Recurring stomach trouble	yes / no
	Not corrected with glasses	yes / no	22)	Recurring bowel trouble	yes / no
7)	Recurring chest pains	yes / no	23)	Have you any disabilities affecting	yes / no
8)	Asthma	yes / no		a) Standing	yes / no
9)	Hay fever	yes / no		b) Walking	yes / no
10)	Heart trouble	yes / no		c) Climbing stairs	yes / no
11)	High blood pressure	yes / no		d) Lifting	yes / no
12)	Varicose veins	yes / no		e) Using your hands	yes / no
13)	Colour blindness	yes / no		f) Working at heights	yes / no
14)	Dyslexia	yes / no		g) Ability to drive	yes / no
15)	Dyscalculia (number dyslexia)	yes / no			
16)	Have you ever suffered from depression, stress, nervous disorders, mental illness, alcohol or drug addiction				yes / no

Do you consider yourself to be disabled: yes / no?

What disability do you class yourself as having: .....?

In the past 2 years have you been off work due to illness or injury: yes / no

If yes, how many days were you off work: .....

Have you made a full recovery from your illness or injury: yes / no?

If you have not made a full recovery then a doctor's certificate will be required stating that you are able to work

Are you at present taking medicines or receiving treatment from your doctor: yes / no?

If you answer yes to the above question then please state what medication you are taking and for what condition(s), as this may effect your ability to perform certain tasks:

Are there any other medical conditions we need to be informed about that could affect your ability to do work safely: yes / no?

If yes, please state below:

Medical conditions other than those above:

Consultants comments:

Health & Safety declaration

I ..... whilst working as a temporary worker for Solutions Recruitment Limited will

(a) not use any machinery unless experienced and able
(b) not work on a dangerous machine (i.e. brake press) unless I am supervised or experienced in the use of the said machinery

I will ensure that all times I will take every precaution to

(a) avoid injury to either myself or others
(b) prevent damage to any equipment or machinery

I hereby declare that the information I have given is to the best of my knowledge true and correct and that if required this information can be passed to Companies should they need to know of any illness or injury that may hinder me from performing any given duties. I also understand that if I withhold information or give misleading answers then I may have my assignment terminated and I will not be eligible for work with Solutions Recruitment Limited until I can provide medical documentation stating that I am fit to work. I also understand that it is solely my responsibility to inform Solutions Recruitment Limited of any changes to my health that may affect my ability to work in the future.

Signed: ..... Date: .....

Night workers questionnaire

1)	Have you worked a night shift before	yes / no
2)	Have you worked a permanent night shift before	yes / no
3)	Do you suffer from heart or circulatory problems	yes / no
4)	If so, does this affect your ability to work nights	yes / no
5)	Do you have a condition where meal times are important	yes / no
6)	Do you suffer from any medical condition affecting your sleep	yes / no
7)	Do you suffer from any chronic chest disorder such as asthma)	yes / no
8)	Do you suffer any condition that requires medication at strict times	yes / no
9)	Have you ever suffered from depression, stress, nervous disorders, mental illness, alcohol or drug addiction	yes / no
10)	Are you aware of any other health factors that would affect your ability to do night work	yes / no
11)	Do you feel night work would adversely affect your health in any way	yes / no

Please use the box below for any additional comments

Night workers declaration

I ..... certify that the information given is true to the best of my knowledge. I know of no reason why I cannot work a night shift and understand that if at any time I am declared unfit to work a night shift then it is my responsibility to inform Solutions Recruitment Limited immediately.

Signed: ..... Date: .....

For office use only

Fit for night work	**yes / no**
Fit for night work with restrictions	**yes / no**
Unfit for night work	**yes / no**