



Medical Questionnaire

Do you suffer from, or have you ever had any health condition as listed below? **Please answer ALL the questions and select either YES or NO as applicable for you.**

Bipolar disorder

No

Depression (if yes, is this past or current)

No

Circulatory problems such as thrombosis or varicose veins

No

Anxiety, panic attacks or stress related issues (if yes, is this past or current)

No

High blood pressure

Yes

Any eating disorders

No

Heart Trouble

No

Any alcohol or drug dependency or misuse

No

Asthma

No

Joint problems

No

Epilepsy or fits

No

Arthritis

No

Migraine headaches (frequent)

No

Diabetes

No

Persistent Cough

No

Rheumatic Fever

No

Any condition that affects your eyesight in any way (after any lens correction)

No

Any condition causing excessive drowsiness or severe pain

No

Any condition that affects your hearing in any way

No

Allergies that may affect you at work (please state)

No

Dermatitis, eczema, psoriasis or any skin allergies or other problems

No

Do you have any other medical condition that would affect your ability to work within the care industry

No

Any condition that affects your physical ability i.e., stamina, walking, balance, bending, kneeling or manual handling

No

Any significant infectious diseases such as tuberculosis or hepatitis

No

Any condition that may impair your consciousness, make you black out, lose concentration or become confused or disorientated

No

Are you taking any regular medication to treat any existing medical conditions that you

would be required to take to work

No

To the best of my knowledge and belief the information given above is correct.

I consent under the Data Protection legislation to the Company processing the information I have provided on this Questionnaire for the purpose of assessing my health and suitability for employment. I understand and agree that the information will be retained for as long as the Company deems necessary, and that the information may be passed to a third party such as a Medical Assessor for comments.

Name

Signed

Date
