Medical in Confidence

	SOMERSET PARTNERSHIP NHS FOUNDATION TRUST	serco
	BASELINE HEALTH QUESTIONNAIRE FOR HEALTHCARE WORKERS	OH30/MH80

PLEASE INDICATE YOUR EMPLOYER

Somerset Partnership – including Dental Access Centre	☐	**NHS Somerset**	☐
GP Practice	☐	**NHS Dental Practice**	☐

SECTION 1 - POST DETAILS *This section MUST be completed by the requesting Manager*

Job Title ..... Department/Team .....

Base/Location ..... Managers name .....

...

Telephone ..... Proposed Start Date .....

Contract status: Full Time ☐ Part Time ☐ Bank ☐ Permanent ☐ Volunteer ☐ Fixed Term ☐ Other ☐

Job hazards associated with this post

Direct patient contact or contact with specimens	☐	Work with Natural Latex products	☐	Work involving driving	☐
Control and restraint or PMVA	☐	Work involving heavy lifting	☐	Shift work/Night work	☐
Work with cytotoxics/genetic modification	☐	Work using display screens	☐	Work involving food handling	☐
Work using skin irritants	☐	Work can be stressful at times	☐	Work in isolation	☐
Work using lung irritants	☐	Carry out Exposure Prone Procedures	☐	Other	☐

SECTION 2 - PERSONAL DETAILS to be completed by employee - *Please print your answers*

Surname/Family Name ..... First Name .....

Title ..... Gender M/F ..... Maiden Name .....

Date of Birth ..... Place of Birth .....

Present Address ..... Telephone .....

..... Post Code .....

Postal Address *(if different to above)* ..... Telephone .....

..... Post Code .....

Have you worked for this organisation before? Yes ☐ No ☐ *If so, please state in what capacity and when below*

As ..... From ..... Until .....

DATA PROTECTION ACT 1998

Personal information generated by completion of this form provides a medical view of your fitness for the role or specific task. Without this information your assessment of fitness will not proceed further. The Occupational Health Adviser or Occupational Physician may require further information about your health before coming to a view on your fitness. Your consent to further reports from your medical advisers will be sought in these circumstances before a certificate of fitness/restrictions/unfitness can be issued. All such medical information will be kept in strict medical confidence by the Occupational Health staff. Your consent will be sought for any other use of all or part of this confidential medical data.

SECTION 3 - JOB HISTORY

Is this your first employment following registration of your professional training? **Yes** ☐ **No** ☐

Please give details below of the previous employment and hazards you have been exposed to

Job	*Employer*	*From (date)*	*To (date)*	*Hazard*
.....	.....	.....		.....
.....	.....	.....		.....
.....	.....	.....		.....

SECTION 4 - PERSONAL HISTORY

		Yes	***No***	***Details*** *Give full information where applicable*
1.	Do you consider yourself to be in good health?	☐	☐	.....
2.	Do you/have you required any modifications or additional equipment in order to do your job for any reason?	☐	☐	.....
3.	Have you been restricted from any particular type of work or had to give up a job for medical reasons?	☐	☐	.....
4.	Have you been absent from work or study for any medical reason for more than 5 days in the last 12 months? *If so, please give cause and approximate dates*	☐	☐	.....
5.	Are you currently taking any prescribed medication on a regular basis?	☐	☐	.....
6.	Have you consulted your own doctor or any other health practitioner (including osteopath) during the past three months?	☐	☐	.....
7.	Have you lived/worked abroad in the past 12 months?	☐	☐	.....
8.	What is your approximate height and weight?	Height ..... cm		Weight ..... kg

SECTION 5 - SMOKING AND ALCOHOL

	Yes	***No***	
1.Do you smoke?	☐	☐	
If yes, quantity per day?			Cigarettes ☐ Pipe ☐ Cigars ☐
If ex-smoker, how many years since you stopped?			1-5 ☐ 5-10 ☐ 10+ ☐
2.Do you drink alcohol?	☐	☐	
If yes, what is your average weekly intake?			Pints ..... Shorts ..... Glasses of wine .....

SECTION 6 - MEDICAL HISTORY

		Yes	***No***	***Details*** *Give full information where applicable*
1.	Are you allergic or sensitive to any substance?	☐	☐	.....
2.	Do you have any allergic conditions e.g. asthma, hay fever, rhinitis?	☐	☐	.....
3.	Do you have, or have you had any skin trouble, e.g. eczema, dermatitis or psoriasis?	☐	☐	.....
4.	Have you had problems with natural rubber such as that found in balloons, gloves or condoms? If so, when did you first notice it, and what problems did you first experience?	☐	☐	.....
		☐	☐	

5. Do you have any food allergies, particularly potato, peanut, egg, banana, almond, mango, milk, kiwi fruit?			.....
6. Do you have, or have you had any chest complaint or ailment, e.g. bronchitis, pleurisy, tuberculosis?	☐	☐	.....
7. Do you have a persistent cough, bring up phlegm or suffer from night sweats?	☐	☐	.....
8. Have you had persistent or recurrent back pain?	☐	☐	.....
9. Do you have any difficulty lifting weights, bending or climbing stairs?	☐	☐	.....
10. Have you had persistent or recurrent pain in your neck/shoulder/arms/hands?	☐	☐	.....

11. Do you suffer from any form of arthritis or rheumatism?			.....
12. Have you suffered from depression, "nerves" or any psychiatric illness?	☐	☐	.....
13. Have you had treatment or support from a counsellor, psychiatrist or psychologist?	☐	☐	.....
14. Have you been treated for weight gain or loss, or diagnosed as having Anorexia Nervosa or Bulimia?	☐	☐	.....
15. Are you dyslexic?	☐	☐	.....
16. Do you have deficiency of colour vision?	☐	☐	.....
17. Do you have any other vision problem or loss that is not totally corrected by spectacles or contact lenses?	☐	☐	.....
18. Do you have, or have you had any other condition or disease affecting the eyes or your eyesight?	☐	☐	.....
19. Do you have any hearing problems or deficiency not corrected by a hearing appliance?	☐	☐	.....
20. Have you had any ear problem or persistent discharge from either ear?	☐	☐	.....
21. Are you diabetic?	☐	☐	.....
22. Have you had any blackouts, seizures or frequent fainting attacks?	☐	☐	.....
23. Have you been diagnosed as having epilepsy? If so, when was your last attack?	☐	☐	.....
24. Do you suffer from frequent headaches or migraine?	☐	☐	.....
25. Have you had any heart trouble, e.g. heart attack, chest pain?	☐	☐	.....
26. Have you been diagnosed as having high blood pressure?	☐	☐	.....
27. Have you had hepatitis or jaundice?	☐	☐	.....
28. Have you had an operation in the last 10 years?	☐	☐	.....
29. Do you have, or have you had any other health problem not mentioned above?	☐	☐	.....
	☐	☐	

SECTION 7 - IMMUNISATION STATUS

Please indicate which of the following illnesses you have had:

Measles ☐ Mumps ☐ Chickenpox ☐ Shingles ☐

Have you had any of the following immunisations or injections? *Please include approximate dates if known*.
Please include photocopies of all records.
This information can usually be obtained from your current/previous employer or your GP.

	Yes	***No***	***Dates***
BCG for tuberculosis	☐	☐	.....
Rubella (German Measles)	☐	☐	.....
Poliomyelitis *(by mouth or injection)*	☐	☐	.....
Varicella (VZV)	☐	☐	.....
Initial course of Hepatitis B	☐	☐	.....
Booster doses of Hepatitis B	☐	☐	.....
Tetanus	☐	☐	.....
Diphtheria	☐	☐	.....
Other			.....

Have you had any of the following tests? *Please include approximate dates and results if known*.
Please include photocopies of all records and results of screening.
This information can usually be obtained from your current/previous employer or your GP.

	Yes	***No***	***Date***	***Result***
Skin test for tuberculosis (Heaf/Mantoux)	☐	☐	.....	
Blood test for rubella (German Measles) immunity	☐	☐	.....	
Blood test for chickenpox immunity (VZV screening)	☐	☐		
Blood test for HIV status	☐	☐		
Blood test for Hepatitis C status	☐	☐		
Blood test for Hepatitis B immunity?	☐	☐	.....	Anti-HBs .....
Blood test for Hepatitis B surface antigen?	☐	☐	.....	HBsAg: .....

SECTION 8 - IMPORTANT - PLEASE READ

Exposure prone procedures: Staff appointed to posts which include performing exposure prone procedures, e.g. all surgeons, some trauma and accident & emergency doctors, some renal staff, all clinical dentists and labour room midwives **must** provide either proof of Hepatitis B immunity (AntiHBs >100 miu/ml) or a negative Hepatitis B surface antigen test less than six months old, with this questionnaire before clearance can be given**.**

FAILURE TO DO SO WILL RESULT IN A DELAY TO YOUR CLEARANCE AND YOU MAY NOT BE ABLE TO START IN THIS POST.

Females only: In order to ensure that an adequate risk assessment for pregnant employees can be carried out to protect both the employee and the baby, your manager should be informed in writing when you find out that you are pregnant. It is not compulsory to do so but may be necessary if modifications to your role are required for the sake of you or the baby's health. If you are pregnant at the time you commence in this post you should inform Occupational Health when you start

SECTION 9 - DECLARATION

I hereby declare that all medical information given by me to Serco Occupational Health is true and accurate to the best of my belief and knowledge.

Signature of Employee ----------

Date ----------

SECTION 10 - ASSESSMENT ***To be completed by the Serco Occupational Health Nurse/Doctor***

Questionnaire initially checked by ..... Date .....

Initial assessment:	***Yes***	***No***	***Date***	***Comment***
Further detail from candidate required	☐	☐	.....	.....
Confirmation of immune status required	☐	☐	.....	.....
Pre-employment MRSA screening only required	☐	☐	.....	.....
Pre-employment Nurse/Doctor assess. Required	☐	☐	.....	.....
First post-registration Post Check required	☐	☐	.....	.....
Doctor's report required. Consent form sent	☐	☐	.....	.....
Referring officer informed of delay	☐	☐	.....	.....

Final assessment:

Fit for the post/course.

Fit for duties/course with restrictions recommended: .....

.....

Unfit. Suitable for review in ..... days / weeks / months.

Unfit. Not suitable for review

Signature ..... *Name* .....

Position *Occupational Health Nurse / OH Consultant* *Date* .....

Please send completed form to:
Work and Wellbeing Service
Bridgwater Hospital
Salmon Parade
Bridgwater
TA6 5AH
wellbeing@sompar.nhs.uk
01278 450874