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NHS PASA Approved Supplier

OCCUPATIONAL HEALTH MEDICAL QUESTIONNAIRE

CONFIDENTIAL

Information contained within this document is governed by the Data Protection Act 1998. Disclosure of information is only with your informed written consent. Recommendations to your employer will be directed to essential information regarding your health and the hazards and risks of your employment and with due reference to other relevant statutory requirements and professional practice.

Personal Information			
Title	Surname	First names	DOB
Home Tel:		Work Tel:	Mobile:
Home Address:		GP Address:	

Occupational Health Screening History	
Name of trust or hospital that gave you most recent screening	
Date of most recent screening	
Were the results in anyway abnormal	

(If the results were abnormal please provide details in the space below)

Details:

Basic Health History		
<u>If your answer to any of these questions is YES or if you are currently taking any medication please provide details in the space below</u>	Yes	No
Is there any aspect of your health which may restrict your ability to work	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently or regularly taking any medicines, tablets, special diets, or injections	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant	<input type="checkbox"/>	<input type="checkbox"/>
Is there any aspect of your medical history which an employer should or might wish to know	<input type="checkbox"/>	<input type="checkbox"/>
Do you require any adjustments to your working environment to undertake your chosen occupation	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any conditions of vision, hearing or speech which might affect your ability to work	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever suffered from any mental illness/depression or alcoholism or drug dependency	<input type="checkbox"/>	<input type="checkbox"/>
Are you attending any hospital for treatment or are you currently on a waiting list for treatment	<input type="checkbox"/>	<input type="checkbox"/>

Basic Health History (Continued)		
Do you now, or have you ever, suffered from or received treatment for	Yes	No
Respiratory (including asthmatic or allergic) symptoms, disorders or diseases	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular symptoms, disorders or diseases	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal symptoms, disorders or diseases	<input type="checkbox"/>	<input type="checkbox"/>
Neurological (including epileptic) symptoms, disorders or diseases	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric symptoms, disorders or diseases	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary symptoms, disorders or diseases	<input type="checkbox"/>	<input type="checkbox"/>
Skin symptoms symptoms, disorders, diseases including reactions to gloves and glove powder	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine (including diabetic) symptoms, disorders or diseases	<input type="checkbox"/>	<input type="checkbox"/>
Haematological symptoms, disorders or diseases	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent sore throat (including treatment for MRSA infections)	<input type="checkbox"/>	<input type="checkbox"/>
Bone or Joint symptoms, disorders or diseases (including back pain)	<input type="checkbox"/>	<input type="checkbox"/>
Imunno-deficiency symptoms e.g. HIV positive diseases or disorders	<input type="checkbox"/>	<input type="checkbox"/>
Stress related disorders or diseases	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol/Drug related symptoms, disorders or diseases	<input type="checkbox"/>	<input type="checkbox"/>
Overseas travel symptoms, disorders or diseases	<input type="checkbox"/>	<input type="checkbox"/>

Chicken Pox or Shingles		
Have you ever had chicken pox or shingles		
Yes	No	Date

Important Information

Whilst past infection often suggests immunity the only true way of ascertaining this is by Blood testing. To confirm if immune or if immunisation is required it is strongly recommended to obtain blood for serology, unless evidence of immunity (on accepted documentation) is provided.

TB History		
Have you ever had a positive TB skin test	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had an abnormal chest x-ray	<input type="checkbox"/>	<input type="checkbox"/>
Have you recently had the mucous you cough up tested for TB	<input type="checkbox"/>	<input type="checkbox"/>
If yes, were you told it was positive	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been told you have Infectious Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how long ago	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been treated with medication for Infectious TB	<input type="checkbox"/>	<input type="checkbox"/>
(If Yes) Are you still taking TB medicine	<input type="checkbox"/>	<input type="checkbox"/>
Did you take all the TB medicine until the health care professional told you that you were finished	<input type="checkbox"/>	<input type="checkbox"/>
Do you live with or have you been in contact with someone who was recently diagnosed with TB	<input type="checkbox"/>	<input type="checkbox"/>

Current TB Symptoms		
Do you have a cough that has lasted longer than three weeks	<input type="checkbox"/>	<input type="checkbox"/>
Do you cough up blood or mucous	<input type="checkbox"/>	<input type="checkbox"/>
Have you lost your appetite	<input type="checkbox"/>	<input type="checkbox"/>
Have you lost weight (more than 10 pounds) in the last two months	<input type="checkbox"/>	<input type="checkbox"/>
Do you have night sweats (need to change the sheets or your clothes because they are wet)	<input type="checkbox"/>	<input type="checkbox"/>

Immunisation History

Have you have any of the following immunisations	Yes	No	Date
Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>	
Poliomyelitis	<input type="checkbox"/>	<input type="checkbox"/>	
Tetanus	<input type="checkbox"/>	<input type="checkbox"/>	
BCG Vaccination	<input type="checkbox"/>	<input type="checkbox"/>	
MMR x 1	<input type="checkbox"/>	<input type="checkbox"/>	
MMR x 2	<input type="checkbox"/>	<input type="checkbox"/>	

SECTION TO BE COMPLETED BY NON EPP (EXPOSURE PRONE) CANDIDATES ONLY

HIV / AIDS (NON EXPOSURE PRONE CANDIDATES ONLY)			
Have you had a HIV blood Test	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date _____ Result: _____
Do you have reason to believe that you may have been exposed to HIV infection in any of the circumstances listed below?			
1. If you are male, engaging in unprotected sexual intercourse with another man; 2. Having unprotected intercourse in, or with a person who has been exposed in a country where transmission of HIV through sexual intercourse between men and women is common; 2. Shared injecting equipment while mis-using drugs. 3. Engaged in invasive medical, surgical, dental or midwifery procedures in parts of the world where infection control precautions may have been inadequate, or with populations with a high prevalence of HIV infection; 4. Had significant Occupational exposure to HIV infected material in any circumstances. 6. Had unprotected sexual intercourse with someone of any of the above categories.			
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Discuss further <input type="checkbox"/>	Notes: _____
IMPORTANT A health care worker who has any reason to believe they may have been exposed to infection with HIV, in whatever circumstances, must seek and follow confidential advice from the Occupational Health Services. Failure to do so, may breach the duty of care to patients.			

HEPATITIS C (NON EXPOSURE PRONE CANDIDATES ONLY)			
Have you had a Hepatitis C antibody check	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date _____ Result: _____
Do you have reason to believe that you may have been exposed to Hepatitis C infection in any of the circumstances listed below?			
1. Receipt of unscreened blood or untreated plasma products (in the UK before September 1991 and 1986 respectively); 2. The sharing of injecting equipment while using drugs; 3. Having been occupationally exposed to the blood of patients known to be infected with hepatitis C, or deemed to be at high risk of infection, by sharps or other injuries (and not subsequently screened and shown to be non-infectious); 4. Receiving medical or dental treatment in countries where hepatitis C is common and infection control precautions may be inadequate.			
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Discuss further <input type="checkbox"/>	Notes: _____
IMPORTANT A health careworker who has any reason to believe they may have been exposed to infection with Hepatitis C, in whatever circumstances, must seek and follow confidential advice from the Occupational Health Services. Failure to do so, may breach the duty of care to patients.			

Required Statement's		
I hereby confirm that I refuse to undergo a HIV screening	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I hereby confirm that I refuse to undergo Hepatitis C screening	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I accept that my agency have informed me of the risk of working without undergoing HIV Screening and/or Hepatitis C Screening	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Proof of Immunity (Please send the following)	
Varicella	You must provide a written statement to confirm that you have had chicken pox or shingles however we strongly advise that you provide serology test result showing varicella immunity
Tuberculosis	We require an occupational health/GP certificate of a positive scar or a record of a positive skin test result (Do not Self Declare)
Rubella, Measles & Mumps	Certificate of “two” MMR vaccinations or proof of a positive antibody for Rubella & Measles
Hepatitis B	You must provide a copy of the most recent pathology report showing titre levels of 100iu/l or above .The report must be an identified validated sample. (IVS)

Proof of Immunity (Please send the following) EPP Candidates Only	
Hepatitis B Surface Antigen	Evidence of a negative Surface Antigen Test Report must be an identified validated sample. (IVS)
Hepatitis C	Evidence of a negative antibody test Report must be an identified validated sample. (IVS)
HIV	Evidence of a negative antibody test Report must be an identified validated sample. (IVS)

Important Information (IVS)
An IVS report defined according to the following criteria
The healthcare worker should show proof of identity with a photograph – NHS trust identity badge, new driver’s licence, credit cards, passport or national identity card – when a sample is taken.

Important Information (Fitness to Work Certificate)
All candidates are screened in accordance with the latest DOH Guidelines. (See DOH Green Book and Health clearance for tuberculosis, hepatitis B, hepatitis C and HIV: New healthcare workers). Locums are considered as new to the NHS and therefore some requirements may vary to those applied by the NHS directly.
If you do not supply adequate proof of immunity we will not be in a position to provide a fitness to work certificate to your agency.

Additional Information		
Have you been on holiday in the last two year if so, please complete fill in the details below		
Country Visited	Date	Duration of stay
Have you worked in a TB Prevalent area, were HIV is also prevalent in the last 3 years		
Yes	No	Date
<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	

Exposure Prone Procedures
Will your role involve Exposure Prone Procedures Yes <input type="checkbox"/> No <input type="checkbox"/>

DECLARATION		
The information supplied is true to the best of my belief. I agree to inform my employer of any health problems prior to been placed so that my health and safety can be protected whilst at work.		
Name	Signature	Date



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BCG Scar Declaration Form

Section to be completed by candidate

Personal Information			
Title: Mr, Mrs, Ms, Miss, Dr	Surname	First names	DOB
Home Tel:	Work Tel:	Mobile:	
Home Address:	GP Address:		

Section to be completed by Health Care Professional (BCG Scar cannot be self declared)

Personal Information			
Title: Mr, Mrs, Ms, Miss, Dr	Surname	First names	GMC OR NMC PIN Number
Address	Post code	Telephone	Fax

Screening Results BCG Scar		
Location of scar	Size of scar	Date that scar was sighted

Screening Results Mantoux – Heaf if no scar present	
Mantoux- The above named patient had a induration 6mm or greater, but less than 15mm so therefore is considered immune/protected against Tuberculosis	<input type="checkbox"/>
Heaf Test- The above named patient has a Grade 2 (II) result so therefore is considered immune/protected against Tuberculosis	<input type="checkbox"/>

Declaration		
I hereby certify that I'm competent and have received appropriate training in the administration and reading of mantoux skin testing and BCG Vaccination Scars.		
Name	Date	Signature



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Proof of immunity to Measles Mumps and Rubella Form

Section to be completed by candidate

Personal Information			
Title: Mr, Mrs, Ms, Miss, Dr	Surname	First names	DOB
Home Tel:	Work Tel:	Mobile:	
Home Address:		GP Address:	

Section to be completed by Health Care Professional (immunity cannot be self declared)

Personal Information			
Title: Mr, Mrs, Ms, Miss, Dr	Surname	First names	GMC OR NMC PIN Number
Address	Post code	Telephone	Fax

Measles, Mumps and Rubella Immunity (TO BE COMPLETED BY PHYSICIAN OR HEALTH PRACTITIONER ONLY)

<input type="checkbox"/> Live vaccines were administered after 1967.			
First Vaccine Date:		Second Vaccine Date:	
<input type="checkbox"/> The patient had a positive Measles titre.		Date of serology:	
<input type="checkbox"/> The patient had a positive Mumps titre.		Date of serology:	
<input type="checkbox"/> The patient had a positive Rubella titre.		Date of serology:	

Signature:

Date:

DOH Green Book

Protection of healthcare workers is especially important in the context of their ability to transmit measles, mumps or rubella infections to vulnerable groups. While they may need MMR vaccination for their own benefit, on the grounds outlined above, they also should be immune to measles, mumps and rubella for the protection of their patients.

Satisfactory evidence of protection would include documentation of:

- having received two doses of MMR, or
- positive antibody tests for measles and rubella.

- For clarification of Exposure Prone Procedure please visit the following link:
http://www.consultantsagency.com/downloads/TCA_epp.pdf
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- For further information on the screening requirements please visit the following link:
http://www.consultantsagency.com/downloads/TCA_Pre_Employment_Information.pdf
- Or
- <http://www.healthierbusinessukltd.co.uk/cinfo.doc>