**GP Medical Questionnaire**

Candidate Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Town: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postcode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

D.O.B: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position Applied for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dear Doctor

The above named person has applied for work through [MHNA].

In order to offer employment in NHS Trusts and Private Care Sectors, it is necessary to establish the candidates current health status. We would therefore ask if you could read, complete and sign the medical questionnaire accordingly. We also require confirmation of you patients immunisations.

Thank you for your co-operation in enabling us to offer the candidate suitable employment.

Yours truly,

[MHNA]

**GP Medical Questionnaire**

Candidate Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your patient ever had musculoskeletal conditions including arthritis, back pain or injury?

Open box YES Open box NO

If ‘YES’ please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your patient have hearing or sight defects?

Open box YES Open box NO

If ‘YES’ please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your patient any history of skin problems or allergies, including rubber, latex, eczema, dermatitis or an adverse reaction to any medication or substance?

Open box YES Open box NO

If ‘YES’ please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your patient have any history of psychological illness (e.g. nerves, phobias, stress, anxiety, depression, eating disorders), or drug or alcohol dependency or misuse (including prescription drugs) ?

Open box YES Open box NO

If ‘YES’ please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your patient suffer from blood pressure problems, epilepsy, blackouts, dizziness?

Open box YES Open box NO

If ‘YES’ please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your patient suffer from diabetes and if so how is this controlled?

Open box YES Open box NO

If ‘YES’ please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your patient suffer from asthma, bronchitis or other chest illness?

Open box YES Open box NO

If ‘YES’ please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your patient suffer from heart or circulatory problems?

Open box YES Open box NO

If ‘YES’ please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your patient ever tested positive for HIV, hepatitis or tuberculosis?

Open box YES Open box NO

If ‘YES’ please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your patient on any medication or have they been on any medication within the past year?

Open box YES Open box NO

If ‘YES’ please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your patient receiving any medical treatment or have they been receiving any medical treatment within the past year?

Open box YES Open box NO

If ‘YES’ please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your patient have any recurring health problems?

Open box YES Open box NO

If ‘YES’ please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your patient had frequent or prolonged periods of absence from work?

Open box YES Open box NO

If ‘YES’ please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please detail below, or attach a separate form, of your patient’s immunisation record:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Finally can you please state that this person is medically fit for work within the healthcare setting and is not at any higher risk to injury or infection due to any medical conditions?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**I verify that the above information is correct to the best of my knowledge:**

**Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please place practice stamp below:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Health Declaration Form**

**Medical History – Please complete as appropriate**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Details |
| Have you seen a GP or hospital doctor during the past year?  **If so you must provide details.** |  |  |  |
| Are you currently receiving injections, medication or treatment (excluding contraception)? **If so you must provide details.** |  |  |  |
| Have you received injections, medication or treatment in the past year (excluding contraception)? **If so you must provide details.** |  |  |  |
| Have you been absent from work due to illness in the last 2 years?  **If so you must provide details.** |  |  |  |
| Have you been treated at hospital in the last year?  **If so you must provide details.** |  |  |  |

**Do you suffer, or have you had any of the following?**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Details |
| Severe, frequent or prolonged headaches? Or migraines? |  |  |  |
| Skin problems or allergies, including rubber, latex, eczema, dermatitis or an adverse reaction to any medication or substance? |  |  |  |
| Raised or low blood pressure? |  |  |  |
| Epilepsy, black outs or dizziness? |  |  |  |
| Diabetes? |  |  |  |
| Asthma, bronchitis, or other chest illness? |  |  |  |
| Chronic or recurrent diarrhoea, Chorones or colitis? |  |  |  |
| Musculoskeletal conditions including arthritis, back pain or injury? |  |  |  |
| Mental health problems or illness (e.g. nerves, phobias, stress, anxiety, depression, eating disorders), or drug or alcohol dependency or misuse (including prescription drugs) |  |  |  |
| Heart or circulatory problems? |  |  |  |
| Have you ever tested positive for HIV, hepatitis B or hepatitis C? |  |  |  |
| Problems with your hands, arms, legs or feet, which affect movement? |  |  |  |
| Do you drink or smoke? |  |  |  |
| Have you ever had Tuberculosis, unexplained weight loss, night sweats or coughing lasting more than 3 weeks? |  |  |  |
| Have you ever lived abroad? |  |  |  |
| Do you have any other medical problems or disability? |  |  |  |
| Have you had any other medical problems or disability in the past year? |  |  |  |

**Have you ever had any of the following diseases?**

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| Chicken Pox |  |  |
| Shingles |  |  |
| Rubella |  |  |
| Hepatitis |  |  |
| Typhoid |  |  |
| Dysentery |  |  |
| Food Poisoning |  |  |

**Please provide the dates you received the following injections?**

|  |  |  |
| --- | --- | --- |
|  | **Received** | **Date** |
| Tetanus |  |  |
| Polio |  |  |
| Tine/Heaf/Mantoux |  |  |
| B.C.G. for TB |  |  |
| Rubella (German Measles) |  |  |
| Hepatitis B |  |  |
| Hepatitis A |  |  |
| Typhoid |  |  |

I declare that the foregoing statements are true and complete to the best of my knowledge and belief, and that I have not wilfully or deliberately withheld any information, which may be relevant to my proposed employment. I also agree to inform [MHNA] if there are any changes in my medical circumstances immediately.

**All healthcare staff must have a GP medical declaration completed and provide an immunisation list.**

Some other categories of staff will also be expected to provide this information.

**Signed by Employee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_**

**Signed by Consultant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_**