EMPLOYEE MEDICAL QUESTIONNAIRE

CONFIDENTIAL

The purpose of the questionnaire is to see whether you have any health problems that could affect your ability to undertake the duties of the post you have been offered or place you at any risk in the workplace. We may recommend adjustments or assistance as a result of this assessment to enable you to do the job. Our aim is to promote and maintain the health of all people at work. Before health clearance is given for employment you may be contacted by the Maxim Care Services and may need to be seen by an occupational health advisor or physician.

PERSONAL INFORMATION

Title:		First Name:		Surname:	
D.O.B		Home Telephone		Mobile:	
Work Telephone:				Email:	
Home Address:				GP Address:	

MEDICAL HISTORY

All staff groups complete this section	Yes ☐No ☐
Do you have any illness/impairment/disability (physical or psychological) which may affect your work?	Yes ☐No ☐
Have you ever had any illness/impairment/disability which may have been caused or made worse by your work?	Yes ☐No ☐
Are you having, or waiting for treatment (including medication) or investigations at present? If your answer is yes, please provide further details of the condition, treatment and dates.	Yes ☐No ☐
Do you think you may need any adjustments or assistance to help you to do the job	Yes ☐No ☐
ADDITIONAL INFORMATION (If you have answered yes to any questions above please provide additional information below)	

TUBERCULOSIS

Clinical diagnosis and management of tuberculosis, and measures for its prevention and control (NICE 2006)			Yes ☐No ☐
Have you lived continuously in the UK for the last 5 years?			Yes ☐No ☐
If you answered no above, please list all the countries that you have lived in over the last 5 years			
Have you had a BCG vaccination in relation to Tuberculosis?			Yes ☐No ☐
If you answered yes please state when		Date:	
Do you have any of the following			
A cough which has lasted for more than 3 weeks	Yes ☐No ☐	Unexplained weight loss	Yes ☐No ☐
Unexplained fever	Yes ☐No ☐	Have you had tuberculosis (TB) or been in recent contact with open TB	Yes ☐No ☐

MAXIM CARE SERVICES
17 Barley Drive, Burton Latimer, Kettering, NN155YU
Email: recruitment@maximcare.uk | **Website:** www.maximcare.uk

ADDITIONAL INFORMATION (If you have answered yes to any questions above please provide additional information below)

CHICKEN POX OR SHINGLES			
Have you ever had chicken pox or shingles?	Yes ☐No ☐	Date:	

IMMUNISATION HISTORY						
Have you had any of the following immunisations?				Yes ☐No ☐	Date:	
Triple vaccination as a child (Diphtheria / Tetanus / Whooping cough)				Yes ☐No ☐	Date:	
Polio				Yes ☐No ☐	Date:	
Tetanus				Yes ☐No ☐	Date:	
Hepatitis B (If Yes is ticked please give dates below)				Yes ☐No ☐	Date:	
Course:	1		2		3	
Boosters:	1		2		3	

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 & Mumps
Hepatitis B	You must provide a copy of the most recent pathology report showing titre levels of 100Iu/l or above

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)

EXPOSURE PRONE PROCEDURES	
Will your role involve Exposure Prone Procedures	Yes ☐No ☐

DECLARATION					
I declare that the answers to the above questions are true and complete to the best of my knowledge and belief. I also give consent for Maxim Care Services to make recommendations to my employer.					
Signed:		Print Name:		Date:	

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