

**Universal Care Services (UK) Ltd**  
**Strictly Confidential**

**PRE-EMPLOYMENT FITNESS ASSESSMENT QUESTIONNAIRE**

The purpose of the questionnaire is to satisfy the obligation we share with you, which is to try to ensure that the work you are applying for will not be detrimental to your health and that you, in turn, are not likely to be a health risk to service users and colleagues.

The questionnaire seeks certain personal sensitive data regarding your physical/mental health. This information will not be used in order to select individuals for employment, but may be used in order to verify the safety of proceeding with either an application or a job offer.

You are therefore requested to complete this form, and sign it. This will indicate your explicit consent to the collection and processing of such data in accordance with the principles of the Data Protection Act.

**Thank you for your co-operation.**

<b>Your name</b>	Title	Initials	First Name	Last name	Position Applied for

<b>Previous Employment (up to last three jobs)</b>		
Job Title	Name of Employer	Length of service (years/months)

<b>Have you worked in countries other than those in Europe, North America or Australasia? If yes, please state where and when.</b>	Yes	No

<b>General Health</b>	If “NO” please tick	If “YES”, please give details:
Have you ever registered as disabled?	☐	
Have you ever claimed industrial injury/disease compensation or benefits?	☐	
Have you ever left or had to modify a job due to illness or injury?	☐	
How much time have you taken as absence from work or school in the last 2 years due to illness or injury?	☐	

<b>Infectious Diseases. Do you have, or have you ever had any of the following?</b>	If “NO” please tick	If “YES”, please give details & dates:
Chicken Pox		
Tuberculosis (TB)		
Hepatitis B or C		
Human Immunodeficiency Virus (HIV)		
<b>N.B.</b> <i>Healthcare Workers who are infected with HIV must remain under regular medical and occupational health supervision (Ref: Dept of Health 1994).</i>		

<b>Immunisations.</b> Have you had any of the following immunisations?	If “NO” please tick	If “YES”, please give dates if known.
<b>TB</b> (BCG)		
TB Skin test (Heaf/Mantoux)		
<b>Rubella</b> (German Measles)		
Rubella blood test		Result:
<b>Tetanus</b>		
<b>Polio</b>		
<b>Hepatitis B</b> Dates of vaccination: Primary Course – Dose 1 Dose 2 Dose 3 Boosters-		
Date and result of <b>last Hepatitis</b> immune level blood test:		

**N.B.** Applicants for jobs involving Exposure Prone Procedures must supply satisfactory evidence of immunity or freedom from infection with respect to Hepatitis B in the form of a copy of a laboratory blood test result, or letter from your doctor (GP or previous Occupational Health Service), confirming immunity or freedom from infection.

**FAILURE TO DO SO WILL CAUSE DELAYS.**

**Medical conditions.** Have you had any of the following? If so, please give full details including any ongoing effects on your day-to-day activities. Please continue on a separate sheet if necessary.

CONDITION	If "NO" please tick	If "YES", please give details:
Fits, blackouts, epilepsy, fainting attacks, severe head injuries, frequent or severe migraine headaches.		
Chest problems including asthma, bronchitis, emphysema, pleurisy, persistent cough or breathlessness.		
Heart or circulation problems e.g. raised blood pressure, angina, stroke, chest pains.		
Eye disease or severe vision defects		
Defective colour vision		
Ear conditions e.g. recurring discharge or hearing loss.		
Mental health conditions e.g. schizophrenia, depression, anxiety states, phobias, eating disorders or self-harm (including overdoses).		
Addiction to alcohol or any other substance.		
Neck, back or other joint problems including arthritis, slipped disc, sciatica, recurrent backache.		
Skin conditions e.g. eczema, psoriasis, dermatitis.		
Gastro-intestinal conditions, including ulcers, irritable bowel syndrome, typhoid or persistent diarrhoea.		
Diabetes, thyroid disease or any other glandular condition.		
Liver/kidney or bladder disease.		
Hernia or rupture.		
Operations (other than minor operations)		
Allergies to any substances.		
Any other medical condition or disability, which you feel, may require adjustment to your work or working environment.		
Are you taking any regular medications? (please list)		
What is your height?		
What is your weight?		
Do you smoke? Yes/No. If yes give details of amount of cigarettes per day or oz of tobacco per week.		
Average alcohol consumption per week in units (1 unit = 1/2 pint beer/lager or 1 glass of wine or 1 measure of spirits).		

**Declaration**

1. I declare that to the best of my knowledge the above information, and that submitted in any accompanying documents, is correct. I understand that any false or misleading information given on this form may result in my dismissal.
2. I consent to a medical interview and assessment if considered necessary.

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

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