PART 1 - HIGH RISK DRIVERS HEALTH QUESTIONNAIRE

Please complete the questionnaire as accurately as possible ensuring that all of the questions are answered. The information in this questionnaire will be used to assess your medical capability for the role and if any reasonable adjustments (as defined under the Equality Act 2010) are required on taking up employment with North Ayrshire Council.

Once complete, please complete the following steps;

1. Arrange for your GP to verify **Part 2** of the form.
2. Contact the Chairperson to arrange an Occupational Health Assessment.
3. Attend the Occupational Health Assessment where **you must bring** this verified questionnaire.

This information will be reviewed by an Occupational Health Nurse. The Council's Occupational Health Provider will retain the questionnaire and no clinical information will be released without prior consent.

SECTION 1 – POST DETAILS

Service		Location	
Job Title		NAY No	

SECTION 2 – PERSONAL DETAILS

First Name		Surname	
Date of Birth		Sex (M/F)	
Address		Family Doctor	
		Address	
Contact Phone No.			

SECTION 3 – JOB HISTORY

Please list your two most recent jobs and employers

Job Title	**Employer**	**From**	**To**

Have you been exposed to any of the following hazards in **any** previous job? If so, did you wear personal protection such as gloves or masks?

	Exposed to Hazard		**Over what period of time**	**Personal protection worn?**	
	YES	**NO**		**YES**	**NO**
Display Screen Equipment (DSE Work)					
Noise					
Vibration					
Asbestos					
Chemicals					
Physically Demanding Work					

SECTION 4 – PERSONAL HISTORY

	YES	NO	Details – give full information where applicable
Do you consider yourself to be in good health?			
Do you consider yourself to be disabled?			
Are you restricted for medical reasons from carrying out any particular type of work?			
Have you had any illness or accident in the last three years which has caused you to be in hospital?			
Have you been in employment at all during the last 12 months?			
Have you had to give up a job for medical reasons?			
Do you take any form of regular physical exercise?			
Are you currently taking any prescribed medication on a regular basis (excluding contraceptive pills)?			
Have you consulted your own doctor or any other health practitioner (including physiotherapist, osteopath etc.) during the last 3 months?			

Please detail periods of sickness/absence over the last two years:-

From		To		Reason	
From		To		Reason	
From		To		Reason	
From		To		Reason	
From		To		Reason	
From		To		Reason	

SECTION 5 – MEDICAL HISTORY

	YES	NO	Details – give full information where applicable
Have you been diagnosed as having high blood pressure?			
Have you had migraine attacks?			
Have you had a chest disease at any time e.g. asthma, bronchitis, pleurisy, tuberculosis?			
Do you have any allergies or allergic conditions e.g. hay fever, allergy to animals?			
Have you had recurrent indigestion, gastric or duodenal ulcer?			
Do you have recurrent diarrhoea or any chronic bowel disease?			

SECTION 5 – MEDICAL HISTORY CONTINUED

Do you have, or have you had a hernia (rupture)?			
Have you had any of the following	**YES**	**NO**	**Details – give full information where applicable**
Have you had any kidney or bladder trouble?			
Do you have diabetes?			
Have you had persistent or recurrent low back pain?			
Have you had persistent or recurrent neck/shoulder pain?			
Have you had persistent or recurrent pain in the arms/hands/wrists?			
Have you received treatment for anxiety/depression or other mental health disorder?			
Have you had treatment or support from a psychiatrist, psychologist or counsellor?			
Have you had any skin trouble, e.g. eczema, dermatitis, psoriasis or skin allergy?			
Do you have difficulty with colour perception?			
Have you any persistent disorder/disease affecting the eyes?			
Do you wear spectacles or contact lenses?			
Have you had any ear disease or persistent discharge from either ear?			
Do you have a hearing deficiency?			
Have you had any operation?			
Do you have dyslexia, reading or writing difficulties?			
Do you have, or have you had any other medical condition not mentioned above?			

PART 2 - HIGH RISK DRIVERS HEALTH QUESTIONNAIRE WITH GP VALIDATION

SECTION 1 - MEDICAL HISTORY

Have you had any of the following	YES	NO	Details – give full information where applicable
Vision			
Other than the need for spectacles or contact lenses, have you ever experienced a disturbance of vision such as double vision, blurring or blind spots?			
Have you ever had to attend an eye specialist?			
Nervous System			
Have you ever had any form of seizure, convulsion, fit, epilepsy, fainting attacks or blackouts?			
Have you lost consciousness or been knocked out in the last 5 years?			
Have you ever experienced sudden dizziness?			
Have you ever had a disease or injury to the brain, such as stroke, mini-stroke, haemorrhage, tumour, head injury, multiple sclerosis, Parkinson's disease or dementia?			
Do you have any form of diabetes			
Mental Health			
Have you ever had any mental health problems in the last 3 years, such as depression, psychosis or disabling anxiety?			
Have you had an issue with drug or alcohol misuse or dependency in the last 3 years?			
Cardiovascular			
Have you ever had a heart attack?			
Have you ever had an irregular heart beat?			
Have you ever had any heart treatment such as coronary artery surgery, stents, a pacemaker or defibrillator inserted?			
Have you ever had any problems with your circulation such as pain in the legs whilst walking?			
Other			
Have you ever had cancer?			
Have you ever had problems with your kidneys, liver or breathing?			
Do you have difficulties with your limbs or spine which can affect your ability to drive?			

SECTION 1 - MEDICAL HISTORY CONTINUED

Do you smoke? (if yes, how many per day)			
Do you drink alcohol? (if yes how many units per day)			

Please list all medications taken, whether prescription or over the counter		
Please list all hospital attendances, whether to a clinic, A & E or for treatment over the last 5 years		

If any of the information supplied above requires clarification you may be contacted by the Council's Occupational Health Provider.

A further medical examination will be required to ensure that the Council is not putting you or service users at risk. Details of any medical examination will not be given to any person outside the Occupational Health Service without your written consent, but general information will be supplied to your proposed employing department to allow them to fully prepare for you commencing employment.

In signing this questionnaire you confirm that all information provided is true to the best of your knowledge. You also accept that if it is subsequently shown that relevant medical information has not been disclosed by you, or has been misleading or false, then it could affect your employment status with North Ayrshire Council.

Signed		Date	

GP VALIDATION

	YES	NO
Are you in possession of this patient's complete medical history		
According to these records and your knowledge of the applicant do the answers given by him/her in Part 2 the questionnaire appear to be correct?		
Are you aware of any other medical information that might be relevant to this application?		

Please enclose copies of any relevant correspondence.

PLEASE NOTE A MEDICAL EXAMINATION IS NOT REQUIRED

GP's Name		**Date**	

Practice Stamp

NB: The applicant will pay any fee required for the completion of this form.