

Pre-Employment Health Questionnaire

<u>Personal Details</u>			
NI Number			
Surname		Forenames	
Home Address			
	Postcode		
Date of Birth			Telephone
<u>Job Details</u>			
Job Title		Full/Part Time	
Site/Dept.		Day/Night Work	

<u>Medical History</u>								
						Yes	No	
Are you currently taking any medication or treatment requiring a strict timetable?						<input type="checkbox"/>	<input type="checkbox"/>	
Have you in the past received compensation for any industrial injury or illness?						<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever had an illness that caused you to be absent from work for more than 3 months?						<input type="checkbox"/>	<input type="checkbox"/>	
Have you been absent from work for any medical reason for more than 10 days in the past year?						<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever had to give up any previous job for medical reasons?						<input type="checkbox"/>	<input type="checkbox"/>	
Do you wear glasses/contact lenses?						<input type="checkbox"/>	<input type="checkbox"/>	
If yes, are these required when carrying out your duties on/near the Railway?						<input type="checkbox"/>	<input type="checkbox"/>	
Have you had or planning to have corrective eye surgery?						<input type="checkbox"/>	<input type="checkbox"/>	
<i>NB: It is a requirement for all contact lens wearers to have with them at all times a spare pair of spectacles when working on or near the line.</i>								
Have you been exposed to any of the following hazards?								
	Yes	No		Yes	No		Yes	No
Lead	<input type="checkbox"/>	<input type="checkbox"/>	Radiation	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Noise	<input type="checkbox"/>	<input type="checkbox"/>
Vibration	<input type="checkbox"/>	<input type="checkbox"/>	Asbestos	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Dust/Fumes	<input type="checkbox"/>	<input type="checkbox"/>
Tar	<input type="checkbox"/>	<input type="checkbox"/>	Chemicals	<input type="checkbox"/>	<input type="checkbox"/>	Compressed Air Conditions	<input type="checkbox"/>	<input type="checkbox"/>
Other [please specify]								
Have you ever suffered from any of the following?								
	Yes	No		Yes	No		Yes	No
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Complaint	<input type="checkbox"/>	<input type="checkbox"/>
Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	Fits/Blackouts	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Deafness	<input type="checkbox"/>	<input type="checkbox"/>	Ear Disease	<input type="checkbox"/>	<input type="checkbox"/>
Migraine	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Eye Disease	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Poor Vision	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>

If YES to any of the above, please give details on page 3, additional pages may be added if required.

I certify that the information given is true to the best of my knowledge and I confirm that I understand and accept the Company's Drugs & Alcohol Policy printed overleaf.

Signed:	Date:
---------	-------

Current Drug and Alcohol policy here

