

The University of Liverpool Occupational Health Service
Pre Exposure Health Questionnaire
Food Handlers
28 Oxford Street
Liverpool L69 7ZN

Surname:

First name:

Date of Birth:

Home address:

Date employment will commence:

Department:

Have you ever had or do you suffer from any of the following:

Yes

No

- | | | |
|--|--------------------------|--------------------------|
| 1. Eyesight problem not corrected with glasses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Hearing problem not corrected with hearing aids? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Difficulty standing, bending, lifting or other movements? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Problems with your joints, including pain, swelling or stiffness? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Back problems? (eg. strain, lumbago, sciatica, slipped disc) | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. A rupture or hernia? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Any skin trouble affecting hands, arms or face? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Difficulty with your memory or your ability to concentrate? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Problems with your ability to carry out normal day to day activities? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Fits, blackouts or Epilepsy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Any allergies? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Any illness which may have been caused or made worse by your work? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you ever left a job through ill health? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Health problems with which you will need additional support at work? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you consider that you have a disability? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Persistent diarrhoea | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Typhoid, Paratyphoid or Enteric Fever? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Runny ears in last 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Are there any restrictions on the weight you may lift or carry? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Any impairment or disability which may affect your ability to work safely? | <input type="checkbox"/> | <input type="checkbox"/> |

If you have answered "Yes" to any of the above, please give further details:

Previous Occupations:

Yes No

Have you applied for a position with or worked in this University before?

[] []

If so, please give department:

How many days sickness absence have you had in the last two years?

It is in your interest that this form is completed accurately. If not, you may be employed for work for which you are unsuitable and which may harm your health. If it is subsequently discovered that any statement is false or misleading, the employer has the right to take appropriate disciplinary action.

Occupational Health staff will assess your answers to determine your fitness for the job for which you have applied, and will report to your employer in general terms. Medical details will only be given to managers in so far as it is necessary for them to discharge their management responsibilities, in accordance with the Data Protection Act.

All my answers are accurate and I understand that any false declaration may prejudice my employment.

Date:

Signed: