

# Fitness standards and Health Questionnaires



Should HEOPS publish  
and endorse health  
questionnaires as well  
as fitness standards?



▶ The difference  
between stupidity and  
genius is that genius  
has its limits

- ▶ Albert Einstein
- ▶ There are a limited number of effective questions and an infinite number of illegal questions.


▶ In politics,  
stupidity is not a  
handicap.

- ▶ Napoleon Bonaparte
- ▶ But in occupational health it leads to ruin.

▶ Judge a man by his questions rather than by his answers.

- ▶ Voltaire
- ▶ Drafting legal and valid questions is far more challenging than providing accurate answers.

# Why is this interesting?

- ▶ Sept 2012 - suggestion from HEOPS member that there is an URGENT NEED for a generic health questionnaire for all student teachers.
  - ▶ Proposed model included questions about ethnic origin, height and tobacco smoking.
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# What does the Data Protection Act Say?

Review any questionnaires to ensure that only information that is really needed is collected.

- ▶ DPA Employment Practices Code para 4.1.5

# What does the Equality Act Say?

- ▶ Questions must be a proportionate means of achieving a legitimate aim.

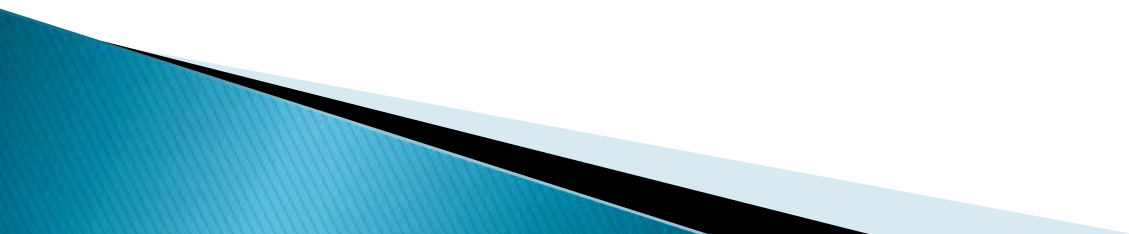
Equality Act Section 13

- ▶ Employers' (or Universities') Occupational Health Services should only ask questions about health with the purpose of establishing whether an employee (or student) will be able to carry out a **“function that is intrinsic to the work concerned”**.

Equality Act Section 60



# Some good and bad examples



# PERSONAL MEDICAL HISTORY

## Have you experienced any of the following?

	Yes	No
1. Migraine or frequent headaches .....		/
2. Fainting or blackouts .....		/
3. Epilepsy, fits or convulsions .....		/
4. Dizziness or light headaches .....		/
5. Head injury .....		/
6. Stroke or paralysis .....		/
7. Eye trouble or injury .....		/
8. Wearing of spectacles or contact lenses .....		/
9. Colour vision defect .....		/
10. Ear problems (eg infection, perforation) .....		/
11. Hearing loss .....		/
12. High blood pressure .....		/
13. Chest pain or tightness .....		/
14. Breathlessness or exertion .....		/
15. Ankle swelling .....		/
16. Heart problems (eg murmur, heart attack) .....		/
17. Varicose veins .....	/	/
18. Asthma .....		/
19. Tuberculosis .....		/
20. Recurrent chest infections (eg bronchitis) .....		/
21. Pneumonia or pleurisy .....		/
22. Other chest or lung disease .....		/
23. Anaemia .....		/
24. Other blood disorder/bleeding tendency .....		/
25. Frequent or severe infections .....		/
26. Any tropical disease .....		/
27. Dental problems or gum disease .....	/	/
28. Throat problems .....		/
29. Recurrent indigestion / heartburn / ulcers .....		/
30. Bowel Disorder .....		/
31. Jaundice, hepatitis or other liver disease .....		/
32. Rectal bleeding or haemorrhoids .....		/
33. Hernia .....		/
34. Unexpected weight loss or gain .....		/
35. Fractures, dislocations or severe sprains .....		/
36. Back or spine problems .....		/
37. Joint problems .....		/
38. Cancer or tumour .....		/
39. Skin problems .....		/
40. Nasal problems .....		/
41. Nervous or mental disorder .....		/
42. Anxiety / depression / stress .....		/
43. Alcohol or drugs related problems .....		/
44. Thyroid problems .....		/
45. Diabetes .....		/
46. Kidney or bladder problems .....		/
47. Sexually transmitted disease .....		/
48. Males - prostate or testicular problems .....		/
49. Females - menstrual problems .....		/
50. Females - ovary / cervix / vagina problems .....		/
51. Females - breast lumps .....		/
52. Other illness / injury / operation .....		/

**Section 2 Your health & functional capabilities**

1. Do you have problems with any of the following:
- a. **Mobility** e.g. walking, running, using stairs ..... Yes  No
  - b. **Agility** e.g., bending, reaching up, kneeling down, maintaining balance..... Yes  No
  - c. **Dexterity** e.g. getting dressed, writing, using tools..... Yes  No
  - d. **Physical exertion** e.g. lifting, carrying, running..... Yes  No
  - e. **Communication** e.g. speech, hearing..... Yes  No
  - f. **Vision** e.g. visual impairment, colour blindness, tunnel vision ..... Yes  No
  - g. **Learning** e.g. dyslexia, dyspraxia, dyscalculia, impaired concentration..... Yes  No
- If **yes** to any of the above, give details e.g. extent of impairment, how you manage, any support needs \_\_\_\_\_

2. Have you ever required special arrangements at school or work to accommodate a disability or health problem? e.g. special equipment, extra time in exams, part-time working ..... Yes  No
- If **yes**, give details \_\_\_\_\_

3. Do you have any of the following:
- a. **Chronic skin conditions?** e.g. eczema, psoriasis..... Yes  No
  - b. **Neurological disorder?** e.g. epilepsy, multiple sclerosis ..... Yes  No
  - c. **Allergies?** e.g. to latex, medicines, foods ..... Yes  No
  - d. **Endocrine disease?** e.g. diabetes ..... Yes  No
- If **yes** to any of the above, give details (e.g. when condition developed, severity, effects, treatment) \_\_\_\_\_

4. Have you ever been affected by:
- a. **Sudden loss of consciousness?** e.g. a fit or seizure ..... Yes  No
  - b. **Chronic fatigue syndrome?** (or similar condition)..... Yes  No
  - c. **An illness requiring more than two week's absence from school or work?** ..... Yes  No
  - d. **Mental health problems?** e.g. anxiety, depression, phobias, OCD, nervous breakdown, personality disorder, over-dose or self-harm, drug or alcohol dependency ..... Yes  No
  - e. **An eating disorder?** e.g. bulimia, anorexia nervosa, compulsive eating ..... Yes  No
- If **yes** to any of the above, give details e.g. when condition developed, how long it lasted, its effects on you, treatment \_\_\_\_\_

5. Have you ever been assessed or treated by a psychiatrist, psychotherapist or counsellor? .. Yes  No
- If **yes** give details e.g. when, reason, outcome \_\_\_\_\_

6. Are you currently taking any medication or treatment? ..... Yes  No

7. Do you have any disability or health condition not already mentioned for which you think you may require support during your education or training?..... Yes  No
- If **yes** to either of the above, give details \_\_\_\_\_

8. What is your height? \_\_\_\_\_ metres      What is your weight? \_\_\_\_ kg

### Health Questionnaire for Healthcare Students

Full Name and title:

Date of Birth:

Address:

Post Code:

Telephone:

Mobile:

Proposed course of study:

You must complete this questionnaire honestly and declare any disability which is, or may be, relevant to your course of study. You must not rely on your own assessment of risks posed to patients from your medical conditions. Non disclosure of relevant information will be treated by the School as a conduct matter and will make it difficult to take a positive and sympathetic approach. You do not have to be legally disabled in order for the School to treat your request for assistance sympathetically.

		Yes	No
1	Do you have any eyesight problems not corrected with glasses?	<input type="checkbox"/>	<input type="checkbox"/>
2	Do you have any hearing problems not corrected with a hearing aid?	<input type="checkbox"/>	<input type="checkbox"/>
3	Do you have any other problems with communication e.g. speech, reading, spelling?	<input type="checkbox"/>	<input type="checkbox"/>
4	Do you have any difficulty with walking, standing, bending, lifting or other movements?	<input type="checkbox"/>	<input type="checkbox"/>
5	Do you have any difficulty with co-ordination of your movements e.g. writing, dressing?	<input type="checkbox"/>	<input type="checkbox"/>
6	Have you ever had any mental health problem? (including anxiety, depression, self harm, eating disorders or addictions)	<input type="checkbox"/>	<input type="checkbox"/>
7	Have you ever been treated by a Psychiatrist, Psychologist or Counsellor?	<input type="checkbox"/>	<input type="checkbox"/>
8	Have you ever had drug or alcohol problems or dependence?	<input type="checkbox"/>	<input type="checkbox"/>
9	Have you ever had any disorder which affects your memory or ability to concentrate?	<input type="checkbox"/>	<input type="checkbox"/>
10	Have you ever had blackouts, epilepsy or any condition causing loss of consciousness?	<input type="checkbox"/>	<input type="checkbox"/>
11	Do you have any allergies?	<input type="checkbox"/>	<input type="checkbox"/>
12	Do you have any skin disorder, such as eczema or psoriasis?	<input type="checkbox"/>	<input type="checkbox"/>
13	Do you have any other medical condition which may affect training or working?	<input type="checkbox"/>	<input type="checkbox"/>
14	Have you been absent from work or study due to illness in the last two years?	<input type="checkbox"/>	<input type="checkbox"/>
15	Are you having or awaiting any investigation or treatment of any kind at the moment?	<input type="checkbox"/>	<input type="checkbox"/>
16	Do you take any regular medication?	<input type="checkbox"/>	<input type="checkbox"/>
17	Have you had any health problem which was caused or made worse by work?	<input type="checkbox"/>	<input type="checkbox"/>
18	Do you have health problems with which you need support during your training?	<input type="checkbox"/>	<input type="checkbox"/>
19	Do you consider yourself to be disabled?	<input type="checkbox"/>	<input type="checkbox"/>
20	Do you have 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 below:


## Health Assessment Online - View Student Questionnaire

### 2. MEDICAL INFORMATION

Please answer all of the following questions. If you answer yes please give details when prompted.

1. Have you had chicken pox or shingles?
2. Do you have any impairment, or side effect from medication, which may affect your ability to work safely?
3. Do you have any eyesight problems not corrected with glasses \ contact lenses?
4. Do you have any hearing problems?
5. Have you ever had any kind of skin problem including eczema/dermatitis?
6. Do you have any difficulty in walking, standing, bending, sitting, lifting or other movements?
7. Have you ever had any back/neck problem or problem with joints including pain, swelling or stiffness?
8. Have you ever had mental illness or psychological problems including depression/anxiety?
9. Have you ever had a drug or alcohol problem or misuse including prescription/recreational drugs?
10. Do you suffer with epilepsy or have you ever had suspected seizure/blackouts?
11. Do you have any allergies including latex?
12. Have you ever had asthma, bronchitis or chest problems?
13. Have you or anyone in your family ever had treatment for Tuberculosis (TB), or have you been knowingly exposed to TB in the last 5 years? If yes please give the exact type of TB.
14. In the last 12 months have you had a cough for more than 3 weeks, ever coughed up blood or had any unexplained loss of weight, fever and night sweats?
15. Have you ever tested positive for Hepatitis or HIV?
16. Do you have diabetes?
17. Do you have a condition where you have compromised immunity?
18. Do you have any other medical conditions not listed on this form?
19. Have you ever had any illness which may have been caused or made worse by your work?
20. Any sickness absence of two weeks or more during school and employment over past five years?
21.  
What is your height? 5 ft/ins What is your weight? 8 st/lbs
22. Have you lived or worked outside the United Kingdom in the last 5 years?

# Proposal:

1. HEOPS should always use the published medical competence standards, from regulatory bodies as the mandatory outcomes, which are exempt from adjustments and which students should achieve on graduation.
  2. HEOPS should publish fitness standards which students should meet at enrolment based upon mandatory outcomes.
  3. HEOPS members should each develop their preferred tools to apply the HEOPS fitness standards.
  4. These tools include health questionnaires and GP forms.
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▶ April 2013

