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?	☐	☐
2	Do you have any hearing problems not corrected with a hearing aid?	☐	☐
3	Do you have any other problems with communication e.g. speech, reading, spelling?	☐	☐
4	Do you have any difficulty with walking, standing, bending, lifting or other movements?	☐	☐
5	Do you have any difficulty with co-ordination of your movements e.g. writing, dressing?	☐	☐
6	Have you ever had any mental health problem? (including anxiety, depression, self harm, eating disorders or addictions)	☐	☐
7	Have you ever been treated by a Psychiatrist, Psychologist or Counsellor?	☐	☐
8	Have you ever had drug or alcohol problems or dependence?	☐	☐
9	Have you ever had any disorder which affects your memory or ability to concentrate?	☐	☐
10	Have you ever had blackouts, epilepsy or any condition causing loss of consciousness?	☐	☐
11	Do you have any allergies?	☐	☐
12	Do you have any skin disorder, such as eczema or psoriasis?	☐	☐
13	Do you have any other medical condition which may affect training or working?	☐	☐
14	Have you been absent from work or study due to illness in the last two years?	☐	☐
15	Are you having or awaiting any investigation or treatment of any kind at the moment?	☐	☐
16	Do you take any regular medication?	☐	☐
17	Have you had any health problem which was caused or made worse by work?	☐	☐
18	Do you have health problems with which you need support during your training?	☐	☐
19	Do you consider yourself to be disabled?	☐	☐
20	Do you have any impairment or disability which may affect your ability to work safely?	☐	☐

If you have answered yes to any of the above please give further details below:

Immunisation history

If you have any serious communicable disease which could be transmitted to patients, such as HIV, Hepatitis B, Hepatitis C or other blood borne viruses, you must declare this in confidence to the Occupational Health Service. If aspects of your training involve a risk of transmission to patients, you must not attend such training until the risk has been assessed and measures to prevent transmission agreed and implemented. You must not rely on your own assessment of the risks posed to patients.

Have you ever had any of the following?

		Yes	No	Date	Result/comments
1	TB test (Heaf or Mantoux)	☐	☐		
2	BCG (TB vaccination)	☐	☐		
3	Hepatitis B immunisation course	☐	☐		
4	Hepatitis B antibody test	☐	☐		
5	MMR immunisation x 2	☐	☐		
6	Chickenpox	☐	☐		

Declaration and Consent

I have answered all questions accurately, honestly and fully.

Signature: Date:

Please take this completed, signed form to your NHS General Practitioner and request that he/she completed the enclosed form. You are responsible for any fee your GP may charge. Please then return this health questionnaire and the signed, stamped GP form directly to ***The Occupational Health Service, The University of Liverpool, 28 Oxford Street, Liverpool L69 7ZN***. Alternatively, you can submit a scanned copy by email in PDF format to ohadmin@liv.ac.uk . Our Occupational Health Nurse will contact you about arrangements for obligatory immunisations and tests. A recommendation with regard to your fitness to train, and any additional support which you may need, will be based on the health questionnaire and the occupational health assessment. 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.

General Practitioner Comments

Student Name: Date of Birth:

Address:

Your patient has applied to train in a branch of healthcare at the University of Liverpool and has completed the enclosed pre-acceptance questionnaire.

Are you in possession of this patient's complete medical history? Yes No

Are you a relative of the applicant? Yes No
(If so it is unethical to proceed and this form must be passed to another doctor who does not have any close personal relationship with the student, in accordance with paragraph 5 of Good Medical Practice)

According to these records and your knowledge of the applicant,
do the answers given in the questionnaire appear correct? Yes No

Is the enclosed vaccination history accurate? Yes No

Are you aware of any additional medical information which may be relevant to this application (please provide details below)

Please note: a medical examination is not required. This form will only be accepted if it is signed by the responsible registered medical practitioner.

Signed: Date:

Print Name:

Practice Stamp:

Thank you for your help.

NB: Any fee required for completion of this form is the responsibility of the applicant.

PLEASE NOTE THIS FORM WILL NOT BE ACCEPTED WITHOUT A LEGIBLE PRACTICE STAMP