Pre-Employment Medical Questionnaire

Business Health Ireland

Thank you for downloading the Business Health Ireland Pre-Employment Medical Questionnaire. This questionnaire is designed to enable us to:

- determine your fitness to safely carry out the duties of a specific role;
- minimise the risk of aggravating a pre-existing condition;
- protect you as a potential employee, and your colleagues and the general public from any medical-related risk;
- recommend appropriate job accommodations or restrictions required to facilitate you carrying out your duties safely and to allow your employer to fulfil their legal and ethical responsibilities.

The information you provide will be stored in this electronic questionnaire, and may also be stored securely in printed form. The data will be held in accordance with Data Protection Legislation. **The medical information you provide in this questionnaire will be treated in the strictest of confidence by Business Health Ireland.** A medical certificate will be issued regarding your fitness for the proposed post, with any job accommodation, restriction that might be required. Confidential medical information will not be provided to your employer without your prior consent. Statistical information may be compiled on an anonymous basis.

Failure to disclose any relevant matter relating to your health may result in your not being employed by the employer and, if already employed by the employer, your employment may be affected and rights to workplace compensation compromised. You may also be requested to attend the Business Health Ireland clinic for a pre-employment assessment in person.

Please complete all sections of the questionnaire as thoroughly and accurately as possible. Certain fields are compulsory, and the questionnaire will only allow you to save and submit it once these questions have been answered. Once you have completed the questionnaire, you can save a copy to your own computer and then click the **Submit** button on the last page. There is also a **Reset** button that will reset all fields should you wish to start again or to give the form to a colleague to complete.

This questionnaire has been designed to allow you to complete it online. You will need the free Adobe Acrobat Reader software (version 8 or higher), which you can download here. Alternatively, you can simply print out this questionnaire and post it to Business Health Ireland at the address below.

If you have any questions regarding this form, please contact Business Health Ireland on +353 (0)21 4355950 or email info@bhi.ie. Thank you for taking the time to complete this questionnaire.

Business Health Ireland, Unit 10B, EastGate Way, Little Island, Co. Cork
Tel: +353 (0)21 4355950 Email: info@bhi.ie Web: www.bhi.ie

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Section 1 | General Information

Company Name:

Candidate Surname:

Candidate First Name(s):

Proposed Position Title:

Address:

Contact Telephone:

Date of Birth:

Marital Status:

- Married ☐
- Single ☐
- Cohabiting ☐
- Divorced ☐
- Widow(er) ☐

General Practitioner:

Section 2 | Occupational History

Employer:	Position:	From:	To:

Have you been out of work in the last three years due to illness or injury? No ☐ Yes ☐ If yes, reason? -

When and length of absence?

How many episodes?

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Section 3 | Personal History

Do you smoke? No ☐ Yes ☐ Ex-Smoker ☐

If yes, how many per day?

If ex-smoker, when did you quit?

Do you drink alcohol? No ☐ Yes ☐ Ex-Drinker ☐

If yes, how many units per day?

If ex-drinker, when did you quit?

Do you exercise? No ☐ Yes ☐

If yes, type of exercise?

If yes, frequency of exercise?

* one unit = one glass of wine **or** one measure of a spirit **or** ½ a pint of beer

Section 4 | Family History

	Age	Current health (if alive)	Cause and age of death (if deceased)
Father			
Mother			
Siblings			
Children			

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Section 5a | Medical History

How would you consider your state of health? Excellent ☐ Good ☐ Fair ☐ Poor ☐

Were you ever or are you currently under medical care? If yes, please provide details. No ☐ Yes ☐

Did you ever have or are you due for surgery? If yes, please provide details. No ☐ Yes ☐

Are you currently taking any form of medication? If yes, please provide details. No ☐ Yes ☐

Are you allergic to any medication or chemical? If yes, please provide details. No ☐ Yes ☐

Section 5b | Medical History: Did you ever suffer from:

		Yes	No
1.	Joint pains, stiffness, arthritis or other disorders of the shoulder, upper limbs, hands?	☐	☐
2.	Joint pains, stiffness, arthritis or other disorders of the hip, lower limbs, feet?	☐	☐
3.	Joint pains, stiffness, arthritis or other disorders of the back, neck?	☐	☐
4.	Muscle pains, tendonitis, soft tissue disorders?	☐	☐
5.	Numbness, tingling of hand, foot, other sites?	☐	☐
6.	Weakness, loss of power of your hand, limb?	☐	☐
7.	Dizzy spell, fits, faints, collapse, black out?	☐	☐
8.	Visual blurring, loss of vision, other visual disorders?	☐	☐
9.	Migraine, Headaches?	☐	☐
10.	Sinus problem, nasal congestion, facial pains, hay fever?	☐	☐
11.	Ear infection, deafness, tinnitus (buzzing in ear), other ear disorder?	☐	☐
12.	Mouth ulcer, poor dentition, weight loss, poor appetite?	☐	☐
13.	Problem swallowing, heart burn, gastric reflux, indigestion, ulcer?	☐	☐
14.	Abdominal pains, change in bowel habit, blood in stools?	☐	☐
15.	Wheeze, cough, coughing up phlegm or blood, difficulty breathing?	☐	☐
16.	Asthma, tuberculosis, other lung condition?	☐	☐
17.	Chest pain, shortness of breath, palpitation, poor exercise tolerance?	☐	☐
18.	Angina, heart attack, irregular heartbeat, other heart condition?	☐	☐
19.	Stroke, transient ischemia attack, high blood pressure, meningitis?	☐	☐
20.	Urinary or kidney disorder, recurrent urine infection, kidney stone?	☐	☐
21.	Gynaecological, obstetric problem?	☐	☐
22.	Thyroid disorder, diabetes, other glandular disorders?	☐	☐
23.	Chronic fatigue, low energy, poor motivation, withdrawn?	☐	☐
24.	Mood disorder, depression, anxiety or stress-related symptoms?	☐	☐
25.	Psychiatric disorder, addiction problem?	☐	☐
26.	Problem sleeping?	☐	☐
27.	Eczema, contact dermatitis, skin allergy, psoriasis, dry skin, other skin disorder?	☐	☐
28.	Fear of height, open spaces, confined space, flying?	☐	☐
29.	Problem with speech and language?	☐	☐
30.	Other significant medical symptoms or conditions?	☐	☐
31.	Previous investigations, treatment for any medical condition including physiotherapy?	☐	☐
32.	Previous exposure to chemical, dust, gas, noise, biological hazards?	☐	☐
33.	Difficulty with shift work, night work?	☐	☐
34.	Are there any tasks you cannot perform due to a health reason or disability?	☐	☐
35.	Are you aware of any need for job modification that you may require?	☐	☐
36.	Have you ever had a compensation claim due to ill health or injury?	☐	☐
37.	Did you ever have to give up a job due to ill health or injury?	☐	☐

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Section 5c | Medical History

If you answered yes to any of the questions in Section 5b, please give details here:

Section 5 | Declaration

By submitting this form to Business Health Ireland, I, <name populated here>, hereby confirm that I understand the nature of this assessment and that I have voluntarily completed this medical questionnaire.

I understand that my medical details will be held in confidence by Business Health Ireland and that no medical information will be released without my informed consent.

I confirm that all information provided is accurate to the best of my knowledge.

I am aware that failure to disclose relevant medical information or the provision of false information may result in either cancellation or variation of any offer of employment.

I consent to (please tick each box to confirm consent):

- Business Health Ireland providing a certificate of my fitness to work (with appropriate recommendation on job accommodation if required) Yes ☐
- Business Health Ireland liaising with my GP concerning my health. Yes ☐
- Undergoing an appropriate medical examination. Yes ☐

I consent to Business Health Ireland disclosing relevant medical information to a named contact in the company.

For printed version of this form, please sign and date below:

Print name

Signed Date

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