**Health Assessment Questionnaire**

[Company Name]

|  |  |
| --- | --- |
| **Surname:** | **Prof[ ]  Dr[ ]  Mr[ ]  Mrs[ ]** **Miss [ ]  Ms[ ]  Other[ ]**  |
| **Forename(s):** |
| **Work Address/Place of Study:** |
| **Tel:       Mobile:       Email:** |
| **Date of birth:**  | **Gender: Male [ ]  Female [ ]**  |

**VACCINATION HISTORY**

Please give details of vaccinations and tests you have had. Where possible, give dates and results.

|  |
| --- |
| **Immunisation History** |
| 1a | MMR vaccination  | Dates: 1st 2nd  |
| 1b | Measles, mumps and rubella blood test | Date:       |
| Result:       |
| 2a | Hepatitis B vaccinations | Date: (1)       |
| Date: (2)       |
| Date: (3)       |
| 2b | Hepatitis B booster | Date:       |
| 2c | Hepatitis B antibody screening | Date:       |
| Result:       |
| 3a | Heaf, Mantoux or Tine test (TB test) | Date:       |
| 3b | BCG (TB vaccination) | Date:       |
| 4 | Polio booster | Date:       |
| 5 | Tetanus booster | Date:       |
| 6 | Have you had chicken pox? | Yes [ ]  No [ ]  Unsure [ ]  |
| 6a | Varicella (chickenpox) blood test | Date:       |
| Result:       |
|  | Varicella immunisations | Dates: 1st 2nd |
| 7 | Other (specify) | Date:       |

**DECLARATION OF HEALTH**

|  |  |
| --- | --- |
| 1. Do you currently have any health problems, including psychological problems, or are you awaiting surgery? | Yes [ ]  No [ ]  |
| 2. Are you presently receiving any prescribed medication, treatment or therapy except contraception? | Yes [ ]  No [ ]  |
| 3. How many days off sick have you had over the past two years? |       |
| 4. Do you have any health or psychological condition that may affect your ability to perform the proposed research activity? | Yes [ ]  No [ ]  |
| 5. Do you have any health condition caused or made worse by work? | Yes [ ]  No [ ]  |
| 6. Do you have any disability or other health condition not mentioned above that may require additional help or support to perform the research activity? | Yes [ ]  No [ ]  |

If you have answered ‘yes’ to any of the above, please give details including dates and how it affects you now. Continue on a separate sheet if necessary.

|  |  |
| --- | --- |
| Question | Further details |
|       |       |
|       |       |
|       |       |
|       |       |

**DECLARATION**

The information in this form is true and complete. I agree that any deliberate omission, falsification or misrepresentation in the form may be grounds for rejecting this application and/or subsequent disciplinary action.

I consent to relevant health information about me being shared between the occupational health service of my employer/place of study and the occupational health service of any NHS organisations where I wish to undertake research activities. I hereby agree to inform the occupational health service of my employer/place of study and of any NHS organisations where I will be conducting research activities of any changes in my health circumstances that may affect my ability to perform the research activity.

I understand my responsibility to notify the occupational health service of my employer/place of study and of any NHS organisations where I will be conducting research activities if I think I have had significant exposure to, or am carrying, a serious communicable condition such as Hepatitis B, Hepatitis C or HIV and to follow advice from a consultant in occupational health or another suitably qualified colleague about treatments and/or modifications to my practice.

I understand the importance of routine infection-control procedures, including the importance of hand hygiene, appropriate use of protective clothing and compliance with local policies in the NHS organisations where I wish to undertake research activities.

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