OCCUPATIONAL HEALTH QUESTIONNAIRE

THIS DOCUMENT SHOULD BE PLACED IN A SEALED ENVELOPE MARKED PRIVATE & CONFIDENTIAL AND RETURNED FOR THE ATTENTION OF THE RO (_____) AREA TEAM.
YOU WILL BE REQUIRED TO UNDERGO TESTING FOR BLOOD BORN VIRUSES AT YOUR OWN COST.

Surname:	First Name:	Date of birth:
Profession: Doctor/Dentist/Optometrist (delete as appropriate)		
Street Address:		
Town/City:	County:	Postcode:
Phone No:	E-mail Address:	
1. Have you lived or worked in a country other than the UK, European countries, New Zealand, USA and Canada?		YES/NO (delete as appropriate)
If YES, which countries?		
Dates:		

2. Do you have any health issues that may affect your ability to undertake the duties of your role?	YES/NO (delete as appropriate)
If YES, please give details.	

3. Infectious diseases:	
3.1. Tuberculosis	
Have you lived continuously in the UK for the last 5 years?	YES/NO (delete as appropriate)
If NO, please list all the countries that you have lived in or visited for more than 4 weeks over the last 5 years:	
Do you have reason to believe that you may have been exposed to tuberculosis?	YES/NO (delete as appropriate)
Have you had TB?	YES/NO (delete as appropriate)

3.2. HIV/AIDS	
Do you have reason to believe that you may have been exposed to HIV infection?	YES/NO (delete as appropriate)
3.3. Hepatitis C	
Do you have reason to believe you may have been exposed to Hepatitis C infection?	YES/NO (delete as appropriate)

4. Health vaccination records	
Please tick all relevant vaccination/immunisations received and show dates.	
Vaccination/Immunisation	**Date received**
Diptheria	
Tetanus	
Polio	
Meningitus	
MMR or	
Measles	
Mumps	
Rubella	
Haemophilus	
Influenza B	
Hep B initial	
Hep B second	
Hep B third	
Tuberculosis	

5. Disclaimer and Signature	
I certify that to the best of my knowledge, the information I have given is correct. I understand that any false statement may affect my inclusion on the National Performers List.	
Signature:	Date: