HEALTH DECLARATION

HEALTH DECLARATION FORM

YOUR DETAILS

Name: _____

Address:_____

Post code:_____

Telephone:_____

Mobile: _____

Email: _____

Fax:_____

If yes, what medication and why? _____

_____

_____

Do you have any conditions which may affect your abilities to perform Day/Night duties? Yes/No

If yes, what? _____

_____

_____

GENERAL HEALTH INFORMATION
(if you answer yes to any questions on this form please provide details)

Have you attended your GP in the last year? Yes/No

if yes, why?_____

Are you currently taking any prescribed medication? Yes/No

Have you ever suffered from Back, Upper Limb or Neck injury / strain? Yes/No

Have you ever suffered from Nervous / mental illness or eating disorder? Yes/No

Do you have, or have you ever suffered from, any of the following medical conditions:

Condition	Yes	No	Details / Dates
Blackouts/ Epilepsy/ Dizzy spells			
Heart/ Circulatory problems			
Hypertension			
Asthma/ Bronchitis/ Pleurisy			
Tuberculosis (TB)			
Eczema/ Psoriasis			
Diabetes			
Major Operations/ Serious illness			
Rheumatism/ Arthritis			
Chickenpox			
Allergies (including Latex)			
Are you sensitive to Glutaraldehyde?			

Have you been screened for Varicella? Yes/No

If not would you agree to be screened? Yes/No

If required would you be willing to be immunised against Varicella (if vaccine is available) Yes/No

Have you ever had a chest x-ray? Yes/No