

**Accredited**

# University Hospitals of Leicester

**NHS Trust**

**Occupational Health Service**

**CONFIDENTIAL STUDENT HEALTH SCREENING QUESTIONNAIRE**

Your answers to the following questions will help us to assess your health in relation to your training and future professional career. The information which you provide will be treated as confidential as described in Leicester Medical School’s Confidentiality Policy. Please be aware that you will be asked to declare that all the statements you make are true to the best of your knowledge and that if it is subsequently shown that medical information was not disclosed by yourself, or was found to be misleading or false, your course may be terminated. Please also be aware that even if you have made a health declaration on your UCAS form that it will need to be declared again on this form. If a health interview or medical examination is required an appointment will be made for you.

Please contact the Occupational Health Service directly (Telephone 0786616358) if you have any difficulties in completing this form.

## Please complete in full.

**PERSONAL DETAILS**

1.

Surname: Click here to enter text. First Names: Click here to enter text.

Previous Names: Click here to enter text. Date of Birth: Click here to enter text.

[ ] Male [ ]  Female

Student number Click here to enter text.

Mobile No: Click here to enter text. E-mail address: Click here to enter text.

General Practitioner with whom you are registered: Click here to enter text.

Surgery Address Click here to enter text. Telephone No:Click here to enter text.

2.

**EDUCATION/EMPLOYMENT HISTORY**

|  |  |  |
| --- | --- | --- |
| **Please list higher education establishments, GAP year experience, and places of employment since leaving school** | **Start Date** | **Finish Date** |
| Click here to enter text. | Click here to enter a date. | Click here to enter a date. |

Have you lived or worked outside of the UK for longer than 1 month in the last 2 years? [ ] Yes [ ] No

**If YES**, please give further details ...Click here to enter text.

## Previous Sickness Absence -

**Have you lost any time from work or education because of illness during the past two years?** [ ] **Yes** [ ]  **No**

**If YES,** please give further details**:**

|  |  |
| --- | --- |
| **Length of Absence** | **Reason for Absence** |
| Click here to enter text. | Click here to enter text. |

3.

**MEDICAL HISTORY**

|  |  |  |  |
| --- | --- | --- | --- |
| **Do you currently have, or have you ever had****any of the following? (please tick)** | **NO** | **YES** | **Details and dates****(on separate sheet if necessary)****If Yes please give more details** |
| Recurrent fits, faints, blackouts or dizzy spells |[ ] [ ]  Click here to enter text. |
| Diabetes |[ ] [ ]  Click here to enter text. |
| Back/neck or shoulder pain lasting more than two weeks, or on more than three occasions |[ ] [ ]  Click here to enter text. |
| Problems with your hands, arms, legs or feetwhich affect movement or use |[ ] [ ]  Click here to enter text. |
| Skin trouble including eczema or dermatitis orpsoriasis |[ ] [ ]  Click here to enter text. |
| Asthma, recurrent bronchitis or shortness of breath |[ ] [ ]  Click here to enter text. |
| Hearing problems, ear infections or dischargingears |[ ] [ ]  Click here to enter text. |
| Eyesight problems including colour blindness |[ ] [ ]  Click here to enter text. |
| Alcohol abuse or abuse of prescription drugs ornon prescription drugs |[ ] [ ]  Click here to enter text. |
| Nervous or mental illness including stress, anxiety, depression or a nervous breakdown |[ ] [ ]  Click here to enter text. |
| An eating disorder including anorexia, bulimia orsignificant weight loss apart from reasonable dieting. |[ ] [ ]  Click here to enter text. |
| A phobia |[ ] [ ]  Click here to enter text. |
| Self harming behaviours |[ ] [ ]  Click here to enter text. |
| Have you had counselling, psychiatric advice or psychotherapy in the past two years |[ ] [ ]  Click here to enter text. |
| A specific learning, literacy or numeracy difficulty (this includes dyslexia, dysgraphia, dyscalculia etc) |[ ] [ ]  Click here to enter text. |
| Any other issues, difficulties or conditions that might affect your ability to undertake the course or course placements |[ ] [ ]  Click here to enter text. |
| Any allergies |[ ] [ ]  Click here to enter text. |
| Have you ever had: MeaslesMumps Chicken pox |[ ] [ ]  Click here to enter text. |
| Have you ever had Tuberculosis (TB) |[ ] [ ]  Click here to enter text. |
| Have you been in close contact with Tuberculosis (TB) |[ ] [ ]  Click here to enter text. |
| During the past 12 months any unexplained:* weight loss
* fever
* night sweats

or cough for more than three weeks |[ ] [ ]  Click here to enter text. |
| Blood borne virus infectione.g. Hepatitis B, C, HIV |[ ] [ ]  Click here to enter text. |
| Have you been to hospital for any tests, treatment or operations during the past three years |[ ] [ ]  Click here to enter text. |
| Have you seen your GP during the past six months |[ ] [ ]  Click here to enter text. |
| Are you waiting for any hospitalappointments or treatment |[ ] [ ]  Click here to enter text. |
| Are you taking medication of any kind at the moment |[ ] [ ]  Click here to enter text. |

4.

**IMMUNISATION HISTORY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Have you ever had any of the following tests?** | **NO** | **YES** | **RESULT** | **DATE(s)** |
| TB skin test |[ ] [ ]  Click here to enter text. | Click here to enter text. |
| Hepatitis B antibodies |[ ] [ ]  Click here to enter text. | Click here to enter text. |
| HIV antibodies |[ ] [ ]  Click here to enter text. | Click here to enter text. |
| Hepatitis C antibodies |[ ] [ ]  Click here to enter text. | Click here to enter text. |
| Chickenpox (VZ) antibodies |[ ] [ ]  Click here to enter text. | Click here to enter text. |
| Rubella Antibodies |[ ] [ ]  Click here to enter text. | Click here to enter text. |

|  |  |  |  |
| --- | --- | --- | --- |
| **Have you ever had any of the following immunisations? Please give the fullest details possible** | **NO** | **YES** | **VACCINATION DATES****1st 2nd 3rd** if applicable |
| Mumps/Measles/Rubella and/or (MMR) |[ ] [ ]  Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Hepatitis B |[ ] [ ]  Click here to enter text. | Click here to enter text. | Click here to enter text. |
| BCG |[ ] [ ]  Click here to enter text. |  |  |
| Poliomyelitis |[ ] [ ]  Click here to enter text. |  |  |
| Diphtheria |[ ] [ ]  Click here to enter text. |  |  |
| Tetanus |[ ] [ ]  Click here to enter text. |  |  |

## DECLARATION

I have answered these questions **completely and truthfully to the best of my knowledge and belief**. I agree to attend for any further necessary advice related to immunisations or follow up checks which are required for my training and future professional career.

The General Data Protection Regulations apply in relation to the personal and special category data we collect and hold about you and your health. We need your informed consent in order to process your data. We have a privacy notice which explains this in more detail. It is displayed in our clinical departments and on our pages on the UHL intranet. You can also request a copy by emailing ohprivacy@uhl-tr.nhs.uk or you can ring us on 0116 258 5307 or 0116 225 5431 and ask for a copy to be sent to you.

I understand that **failure to make a full declaration of health may lead to the termination of my course** and that failure to give full information will result in an unnecessary delay in my health clearance.

I agree to attend Occupational Health clinics when requested, to discuss having immunisations and/or tests required for this course in order to protect my health and the health of others whilst I am in healthcare training.

I understand that it is my responsibility to inform the Occupational Health Service if I have, or I develop in the future, any infectious condition (including blood borne viruses, e.g. HIV, Hepatitis B & C), psychological or psychiatric condition, or any medical condition that might put patients, colleagues or other staff at risk.

I understand that I may be required to attend the University Occupational Health Department prior to admissions day and that **any change in my health prior to commencing the course, must be immediately notified to my admissions officer.**

I give my **consent** to Occupational Health consulting my GP or hospital specialist or any other Occupational Health Service to seek additional information or clarity regarding my fitness for the course and to communicate advice relating to this and in regard to my fitness for study to the University.

I give my **consent** for University Hospitals of Leicester NHS Trust Occupational Health Service to hold and process my medical information in order to identify any potential issues with regards to my fitness for training both prior to and after A Level results day enabling them to suggest adjustments if required. I understand if I am not subsequently admitted to the University my occupational health records will be destroyed.

Type your name to agree to the above declaration: Click here to enter text.

Date: Click here to enter a date.

**Once complete, please email this form to** **OH.LMS@uhl-tr.nhs.uk**