**CONFIDENTIAL**

# OCCUPATIONAL HEALTH SERVICE

**PHYSIOTHERAPY 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. 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 department directly (Telephone: 07866163581 or email [LUMSOH@uhl-tr.nhs.uk](mailto:LUMSOH@uhl-tr.nhs.uk)) if you have any difficulties in completing this form.

**Please PRINT clearly, complete the form in BLACK ink and return to:**

Joanne Clayton

Occupational Health Nurse

Occupational Health Department

Balmoral Building, Level 0

Leicester Royal Infirmary

Leicester

LE1 5WW or by email to [LUMSOH@uhl-tr.nhs.uk](mailto:LUMSOH@uhl-tr.nhs.uk)

*For all sections, if you do not have enough room, use the space on page 5 to add in any required information.*

## PERSONAL DETAILS

1.

Surname ................................................................. First Names ...................................................….……….

Previous Names ..................................................... Date of Birth ......................................... (Male / Female)

.............................................…………………………………………….………………………………………

Student/UCAS Numbers ………………………….……………………………………………………….

Mobile No……..................................................... E-mail address ………………...................……….…….

General Practitioner with whom you are registered ...........................................................................…………

Surgery Address ....................................................................................................................…………………..

…………………………………………………… Telephone No...................................................................

2.

### EDUCATION/EMPLOYMENT HISTORY

|  |  |  |
| --- | --- | --- |
| Please list higher education establishments, GAP year experience, and places of employment since leaving school | Start Date | Finish Date |
|  |  |  |

Have you lived or worked outside of the UK for longer than 1 month in the last 2 years? Y / N

If YES, please give further details ....................................................................................................…………..

...........................................................................................................................................................…………..

**Previous Sickness Absence -**

**Have you lost any time from work or education because of illness during the past two years? Y / N**

**If yes, details:**

|  |  |
| --- | --- |
| **Length of Absence** | **Reason for Absence** |
|  |  |

### MEDICAL HISTORY

3.

|  |  |  |  |
| --- | --- | --- | --- |
| **Do you have or have you had any of the following?** | **NO** | **YES** | **Details and dates**  **(on back sheet if necessary)** |
| Recurrent fits, faints, blackouts or dizzy spells |  |  |  |
| Diabetes |  |  |  |
| Back/neck or shoulder pain lasting more than two weeks, or on more than three occasions |  |  |  |
| Problems with your hands, arms, legs or feet which affect movement or use |  |  |  |
| Skin trouble including eczema or dermatitis or psoriasis |  |  |  |
| Asthma, recurrent bronchitis or shortness of breath |  |  |  |
| Hearing problems, ear infections or discharging ears |  |  |  |
| Eyesight problems including colour blindness |  |  |  |
| Alcohol abuse or abuse of prescription drugs or non prescription drugs |  |  |  |
| Suffered from a nervous or mental illness including stress, anxiety, depression or a nervous breakdown. |  |  |  |
| Suffered from an eating disorder including anorexia, bulimia or significant weight loss apart from reasonable dieting. |  |  |  |
| Suffered from a phobia |  |  |  |
| Have you ever self harmed |  |  |  |
| Have you had counselling, psychiatric advice or psychotherapy in the past two years |  |  |  |
| Do you have any specific learning, literacy or numeracy difficulties [this includes dyslexia, dysgraphia, dyscalculia, etc] |  |  |  |
| Any other issues, difficulties or conditions that might affect your ability to undertake the course or course placements |  |  |  |
| Any Allergies |  |  |  |
| Have you ever had:  Measles  Mumps  Chicken pox |  |  |  |
| Have you ever had Tuberculosis (TB) |  |  |  |
| Have you been in close contact with tuberculosis (TB) |  |  |  |
| During the past 12 months any unexplained:  - weight loss  - fever  - night sweats  or cough for more than three weeks |  |  |  |
| Blood borne virus infection  e.g. Hepatitis B, C, HIV |  |  |  |
| Have you been to hospital for any tests,  treatment or operations during the past three years |  |  |  |
| Have you seen your GP during the past  six months |  |  |  |
| Are you waiting for any hospital  appointments or treatment |  |  |  |
| Are you taking medication of any kind at the moment |  |  |  |

4.

### IMMUNISATION HISTORY

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Have you ever had any of the following immunisations? Please give the fullest details possible** | **NO** | **YES** | **VACCINATION DATES**  **(First) (Second) (Third)** | | |
| Mumps/Measles/Rubella (MMR) |  |  |  |  |  |
| Hepatitis B |  |  |  |  |  |
| BCG |  |  |  |  |  |
| Poliomyelitis |  |  |  |  |  |
| Diphtheria |  |  |  |  |  |
| Tetanus |  |  |  |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Have you ever had any of the following tests?** | **NO** | **YES** | **RESULT** | **DATE(s)** | | |
| Rubella antibodies |  |  |  |  |  |  |
| TB skin test |  |  |  |  |  |  |
| Hepatitis B antibodies |  |  |  |  |  |  |
| HIV antibodies |  |  |  |  |  |  |
| Hepatitis C antibodies |  |  |  |  |  |  |
| Chickenpox (VZ) antibodies |  |  |  |  |  |  |

**DECLARATION** (continued on page 5)

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](mailto:ohprivacy@uhl-tr.nhs.uk) or you can ring us on 0116 2585307 or 0116 2585431 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 department if I have or develop in the future, any infectious or medical condition (including blood borne viruses, e.g. HIV, Hepatitis B & C and psychological/psychiatric) that might put patients, colleagues or other staff at risk.

**DECLARATION** (continued from page 4)

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 the University Occupational Health Department 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 reasonable adjustments if required. I understand if I am not subsequently admitted to the University of Leicester, that my records will be destroyed.

Signed .................................................................................... Date ...................................................………….