



Health Check Questionnaire

Please indicate whether you have ever suffered or had problems relating to the following by entering YES or NO where applicable

<input type="checkbox"/> Allergies	<input type="checkbox"/> Typhoid	<input type="checkbox"/> Epilepsy/Blackouts
<input type="checkbox"/> Bronchitis/Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Back/Joint problems
<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Migraine	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Any other condition?

If you have YES to any of the above, please give details on a separate page of the illness/condition, the year the problem arose, it's duration and details of treatment.

Please answer YES or NO to the following questions concerning your present health

Are you currently seeing your doctor about a problem?

Are you a smoker?

Please state whether you have had any of the following inoculations

<input type="checkbox"/> German Measles	If YES, date of inoculation	<input type="text"/>
<input type="checkbox"/> Polio	If YES, date of inoculation	<input type="text"/>
<input type="checkbox"/> BCG (Tuberculosis)	If YES, date of inoculation	<input type="text"/>
<input type="checkbox"/> Hepatitis B	If YES, date of inoculation	<input type="text"/>
<input type="checkbox"/> Tetanus	If YES, date of inoculation	<input type="text"/>

Please answer YES/NO if you have had any illness associated with, or contact with

Methicillin Resistant Staphylococcus Aureus (MRSA)

Any infectious disease

Any serious physical or mental illness

Any surgery that would influence work practice

If you have YES to any of the above questions, please give details on separate page

I have answered the above questions to the best of my knowledge and understanding, and have omitted no relevant details. I certify that I am at present in good physical and mental health. I accept that I may be required to undertake a medical check. I also understand that if any false statements are knowingly made this may result in my dismissal from ENTRUST Social Care.

Signed Date

Print Name