

**Occupational Health Service**

**Email** [ohenquiries@uhb.nhs.uk](mailto:ohenquiries@uhb.nhs.uk)

**Telephone** 0121 371 7170

**Pre Course Health Questionnaire**

The information you disclose in this questionnaire will remain confidential to the Occupational Health Department and will be used only to assess your fitness for your proposed course. You will be responsible for disclosing medical information to the University, reasonable adjustments may be made by the University for medical conditions and/or disabilities.

Your Course Tutor and the Admissions Office will only receive an opinion as to your fitness for the course. The information you give will be stored on the dedicated Occupational Health electronic record system and will be treated in strictest confidence by the Occupational Health Department in compliance with the Data Protection Act (1998) unless explicit consent is given for further disclosure. In accordance with this Act, you may have access to your records at any reasonable time. If you require a copy of any part of your record, this will only be supplied upon written request, which may incur a cost. In some cases, it may be necessary to ask you to attend a health interview.

**Please send copies of documentary evidence. DO NOT SEND ORIGINALS.**

**We would recommend you retain copies of all completed forms for your own records.**

**You will only be contacted if there is a need for clarification with your health clearance.**

**PLEASE RETURN THE COMPLETED HEALTH DECLARATION AND IMMUNISATION RECORD (separate documents) to [ohenquiries@uhb.nhs.uk](mailto:ohenquiries@uhb.nhs.uk). THEY MUST BE RECEIVED NO LATER THAN 23/06/2022.**

# Health Questionnaire

Forenames: .....Dr/Mr/Mrs/Miss/Ms

Contact Telephone Number/s:

Surname: .....

Home:.....

Date of Birth:.....

Mobile: .....

Country of Birth.....

Address: .....

Email: .....

.....Post Code: .....

Proposed Course: .....

Start Date of Course: .....

If you answer 'yes' to any of the questions numbered 1 - 17, please give details in the space provided, including: treatment given, hospital admissions, time required off work / school, and any effect on your work, study or leisure activities. Please also indicate if the problem is still current, or now resolved.

**Failure to give adequate information may delay your health clearance.**

Do you or have you ever had:-		Yes/ No	Dates/Details/Current/Resolved
1	A physical or mental disability or condition which has a substantial effect on your ability to carry out normal day-to-day activities, or impair your mobility or manual dexterity?		
2.	Problems with your vision in either eye not corrected by glasses?		
3.	Difficulty with your hearing?		
4.	An injury or disease requiring treatment of any kind?		
5.	Suffered from any chest ailments? (asthma/bronchitis)		
6.	Any skin condition? (eczema/psoriasis/dermatitis)		
7.	Any known allergies?		
8.	Suffered from epileptic fits, faints or blackouts?		
9.	Are you taking or have you taken prescribed medication during the last 2 years?		
10.	Evidence of infection with Hepatitis B, Hepatitis C or HIV?		
11.	Suffered from any mental health disorder?		
12.	Taken a drug overdose, tried to harm yourself or attempted suicide?		
13.	Suffered from any illness requiring psychotherapy/counselling in the last five years?		

14.	Suffered from an eating disorder of any kind?		
15.	Learning disabilities such as Dyslexia?		
16.	Are you attending, or waiting to attend your GP or hospital for treatment or surgery? If yes, give a brief outline why.		
17.	Any other medical problems, not already mentioned on this form, which may affect your course in any way?		

Do you have, or have you recently had any of the following:

***If 'yes', give details***

- |   |                 |       |
|---|-----------------|-------|
| • persistent coughing lasting more than two weeks | <b>Yes / No</b> | ..... |
| • coughing up blood                               | <b>Yes / No</b> | ..... |
| • unexplained weight loss                         | <b>Yes / No</b> | ..... |
| • unexplained fever                               | <b>Yes / No</b> | ..... |
| • night sweats                                    | <b>Yes / No</b> | ..... |

Have you lived outside of the UK for three months or more during the last 12 months, or do you intend to live outside of the UK for 3 months or more prior to starting this course?

***If 'yes', please give details of where and period of time*** **Yes / No** .....

.....

***Have you ever been diagnosed with Tuberculosis? Yes / No***

Have you been in close contact with a friend or relation found to be suffering from tuberculosis in the last two years?

***If 'yes', please give details: Yes / No Details:*** .....

### **All applicants to sign Declaration**

I understand the purpose of the pre-course health questionnaire and declare that the information I have provided is true and complete to the best of my knowledge. Where necessary, I agree that the Occupational Health Department may obtain screening and immunisation details as required to assist in the assessment of my fitness for the course.

I understand that failure to disclose information may be detrimental to my health and could affect my student status leading to a termination of my enrolment as a student.

I give my consent for my Immunisation and Vaccination history to be released to the University of Birmingham. I understand and agree that this information will need to be released to Occupational Health staff at NHS Trusts due to course requirements and future employment for confirmation of vaccinations and antibody status.

I give my consent for the Occupational Health Department to advise the University where it relates to or impacts on my fitness to practise. I understand the Occupational Health Department may also advise the University of any adaptations, considerations or restrictions that may be required.

**Please note – If your health status changes in any way following the completion of this health questionnaire, you MUST contact our Occupational Health Department in writing notifying us of the changes in your health. Please sign below when you have read, understood and accepted the declaration.**

***Please print name below signature***

**Signature**.....**Date**.....

**Print Name**.....