

PRE-EMPLOYMENT MEDICAL EVALUATION QUESTIONNAIRE



The University of Dublin, Trinity College

Please find attached your pre-employment medical screening questionnaire. This should be filled out and sent by email to preemp@tcd.ie. The questionnaire should only be sent to this email address as it will contain personal medical information. Returning it by email will indicate that you have consented to the Declarations at the bottom of the questionnaire.

The College reserves the right to request candidates to attend the College Health Centre or a Doctor of our nomination for a full medical examination.

Should you have any questions concerning this medical, please contact me or Dr McGrath, Director, at the College Health Centre via the email address above.

General Information

Name

Address

Telephone:

Home _____ Mobile _____

Email _____

Date of Birth _____

Nationality _____

Position to be taken up _____

Any additional information about the working environment _____

Name and Contact Details of Current Doctor _____

1. Statement of Present Health

Please complete the following questions by ticking the relevant box. Be sure to provide all additional details in the space that follows.

1.1 How would you describe your level of present health?

Excellent Good Fair Poor

Please explain:

1.2 Do you have a disability as defined under the Employment Equality Act or Disability Act?

Yes No

If yes, please specify:

1.3 Do you smoke?

Yes No

If yes, please specify quantity smoked per day:

1.4 Do you drink alcohol?

Yes No

If yes, please quantify your weekly intake:

1.5 Do you take non-prescription drugs regularly?

Yes No

Please specify:

1.6 Do you take prescription drugs regularly?

Yes No

Please specify:

1.7 Do you use recreational drugs?

Yes No

Please specify:

1.8 Are you currently under the medical care of a doctor or hospital?

Yes No

Please specify:

1.9 Are you currently on a waiting list for hospital treatment?

Yes No

If so, please indicate the nature of the problem:

1.10 How often have you visited your doctor in the last year?

Please specify:

1.11 Are you currently required to wear glasses or contact lenses?

Yes No

Please specify:

1.12 Do you have problems or have you had any problems in the past with any of the following:

- | | | | | |
|------------------------------|-----|--------------------------|----|--------------------------|
| • Standing | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| • Walking | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| • Lifting | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| • Bending | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| • Moving your neck or back | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| • Using your hands or elbows | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| • Working at heights | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| • Climbing stairs | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |

2. Past Medical History

Please complete the following questions by ticking the relevant box. Be sure to provide all additional details in the space that follows.

2.1 Have you ever been denied a job on health grounds?

Yes No

Please specify:

2.2 Have you ever applied for or received compensation for a disease, accident or injury?

Yes No

Please specify:

2.3 Have you received care on an ongoing basis for a doctor or hospital in the past five years?

Yes No

Please specify:

2.4 Have you ever been absent from work due to illness/injury for a continuous period in excess of two weeks?

Yes No

Please specify:

2.5 Have you ever been treated or had counselling for alcohol or drug abuse?

Yes No

Please specify:

2.6 Have you ever attended a manual handling course?

Yes No

2.7 Have you ever worked in an environment which led to exposure to:

- Chemicals? Yes No
- Excessive dust? Yes No
- High levels of noise? Yes No

If so, please provide details:

2.8 Have you ever had or do you now suffer from any of the following:

- Lung/chest problems? *e.g. asthma, TB, pneumonia, bronchitis*

Yes No

Please specify:

- Heart problems or circulatory disorders? *e.g. heart murmur, heart attack, high blood pressure*

Yes No
Please specify:

- Stomach/bowel/liver/gallbladder or pancreatic problems?

Yes No
Please specify:

- Kidney disorder? *e.g. Kidney stones/infections or kidney failure?*

Yes No
Please specify:

- Glandular problems? *e.g. diabetes or thyroid problem*

Yes No
Please specify:

- Disorders of the nervous system? *e.g. fits, blackouts, migraine, epilepsy, stroke*

Yes No
Please specify:

- Psychiatric or mental health problems? *e.g. anxiety, depression, nervous breakdown, anorexia or attendance with a psychiatrist*

Yes No
Please specify:

- Have you ever suffered from a fatigue syndrome? *e.g. post viral fatigue, M.E., burnout etc.*

Yes No
Please specify:

- Eyes, ears, nose or throat problems?

Yes No
Please specify:

- Sexually transmitted or tropical diseases?

Yes No
Please specify:

- Skin problems? *e.g. moles, eczema, dermatitis, psoriasis*

Yes No
Please specify:

- Tumours – benign or malignant?

Yes No
Please specify:

- Have you ever had an operation?

Yes No
Please specify:

- Have you any allergies?

Yes No
Please specify:

- Have you ever had any gynaecological problems?

Yes No
Please specify:

- Any other accidents, illness or injuries?

Yes No
Please specify:

- Neck or back trouble? *e.g. muscular problems, whiplash, disc prolapse*

Yes No
Please specify:

- Arthritis, joint problems, gout?

Yes No
Please specify:

- Work Related Upper Limb Disorder (WRULD) or Repetitive Strain Injury (RSI), tendonitis?

Yes No
Please specify:

3. Noise Questionnaire: **Required** **Not Required**

Please answer the following questions, providing details in the event of a “yes” answer.

3.1 Difficulty hearing?

Yes No

Please specify:

3.2 Buzzing noises (tinnitus) in your ears?

Yes No

Please specify:

3.3 The feeling that people were not speaking clearly?

Yes No

Please specify:

3.4 Difficulty hearing people in a crowded room?

Yes No

Please specify:

3.5 Family history of deafness?

Yes No

Please specify:

3.6 A head injury or blows to the head/ears?

Yes No

Please specify:

3.7 Have you ever been in military service or worked for the FCA?

Yes No

Please specify:

3.8 Have you ever had an audiogram (hearing test)?

Yes No

Please specify:

3.9 Have you ever worn hearing protection at work?

Yes No

Please specify:

3.10 Have you ever had or do you have noisy hobbies? e.g. *hunting/shooting, auto racing, loud music etc.*

Yes No

Please specify:

Declaration

I declare that the information I have given is true and complete to the best of my knowledge and that I have not withheld any material facts. I understand that I am responsible for the accuracy of my statements and that if I wilfully suppress any information that I risk the loss of the appointment.

Signed: _____ **Date** _____

I understand that the purpose of this pre-employment medical is to establish the following:

- *that I am fit for the job*
- *that I can carry out the job without any undue risk to the health and safety of myself or others at work*
- *that my employer will have reasonable expectations that I will provide regular attendance at work until retirement*

*I consent to an examination on behalf of **The University of Dublin, Trinity College** and I agree that the College Health Service may forward my report to that company.*

I understand that the relevant details of my personal/medical history may be disclosed to the Staff Office at the discretion of the College Health Service.

Signed: _____ **Date** _____

I understand that if there are any details of a personal/private nature which I do not wish to have disclosed to the College that I should indicate this to the examiner at the time of the medical examination. Any details of a confidential nature will thus be kept strictly between the examiner and myself.

Consent to Seeking Medical Information

I consent to the College Health Service seeking further information from any doctor or health professional who at any time attended me concerning anything which affects my physical or mental health if deemed necessary by the College Health Service.

Signed: _____ **Date:** _____