

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Information contained within this document is governed by the data protection Act 1998. Disclosure of information is only with your informed written consent. The information is assessed by United Opticare, who will advise on your fitness to practise. Please ensure the health statement is completed fully.

Your GP Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Telephone No \_\_\_\_\_

## NHS OR OTHER SCREENING HISTORY

Name of Trust hospital or client which gave your most recent screening: \_\_\_\_\_

Date of most recent screening: \_\_\_\_\_ Were the results in any way abnormal? Yes ☐ No ☐

(If the results abnormal, please provide details in the space provided below)

## BASIC HEALTH HISTORY

If your answer to any of these question is YES, OR If you are currently taking any medications, please give details in the space provided below:

Is there any aspect of your health which may restrict your ability to work as a doctor? Yes ☐ No ☐

Are you currently, or regularly taking, any medicines, tablets, special clients or injections? Yes ☐ No ☐

Is there any aspect of your medical history about which an employer should or might wish to know? Yes ☐ No ☐

Would you require any adjustments to the working environment to work as a doctor? Yes ☐ No ☐

Do you have any conditions of vision, hearing or speech which might effect your ability to work as a doctor? Yes ☐ No ☐

Have you ever suffered from any mental illness / depression or alcoholism or drug dependency? Yes ☐ No ☐

Are you attending any hospital for treatment, or are you on a waiting list for hospital treatment? Yes ☐ No ☐

Do you now, or have you ever, suffered from or received treatment for:

a) Respiratory (including asthmatic or allergic) symptoms, disorders or diseases? Yes ☐ No ☐

b) Cardiovascular symptoms, disorders or diseases? Yes ☐ No ☐

c) Gastrointestinal symptoms, disorders or diseases? Yes ☐ No ☐

d) Neurological (including epileptic) symptoms, disorders or diseases? Yes ☐ No ☐

e) Psychiatric symptoms, disorders or diseases? Yes ☐ No ☐

f) Genitourinary symptoms, disorders or diseases? Yes ☐ No ☐

g) Skin symptoms, disorders or diseases, including reaction to gloves / glove powder? Yes ☐ No ☐

h) Endocrine (including diabetic) symptoms, disorders or diseases? Yes ☐ No ☐

i) Haematological symptoms, disorders or diseases? Yes ☐ No ☐

j) Recurrent sore throat (including any treatment required for MRSA infection)? Yes ☐ No ☐

k) Bone or joint symptoms, disorders or diseases (including back pain)? Yes ☐ No ☐

l) Immuno-deficiency symptoms, disorders or diseases? Yes ☐ No ☐

m) Stress related symptoms, disorders or diseases? Yes ☐ No ☐

n) Alcohol / drug related symptoms, disorders or diseases? Yes ☐ No ☐

o) Overseas travel related symptoms, disorders or diseases? Yes ☐ No ☐

p) Contact with MRSA? Yes ☐ No ☐

Have you had any of the following illnesses / diseases?

Rubella (German Measles)\*

Varicella (Chicken Pox)\*

Measles

Hepatitis C

Do you have a visible BCG scar of at least 4mm diameter?\*

Have you had at least 2 Tetanus boosters since age 12?

Please indicate YES or NO and give date

Yes ☐ No ☐ Date \_\_\_\_\_

Yes ☐ No ☐ Date \_\_\_\_\_

Yes ☐ No ☐ Date \_\_\_\_\_

Yes ☐ No ☐ Date \_\_\_\_\_

Yes ☐ No ☐

Yes ☐ No ☐

Have you had a Tuberculosis test?

Heaf / Tine/ Mantoux (delete as appropriate)

Yes ☐ No ☐ Date \_\_\_\_\_

Result \_\_\_\_\_

Tick if immunisation  
took place in UK

☐

**Please provide written evidence to support the stated result**

Have you ever had any of the following immunisations?

Rubella (German Measles)\*

Varicella (Chicken Pox)\*

MMR (Mumps, Measles, Rubella)

Diphtheria

Poliomyelitis

Tetanus

Please indicate YES or No and give date

Yes ☐ No ☐ Date \_\_\_\_\_

Yes ☐ No ☐ Date \_\_\_\_\_

Yes ☐ No ☐ Date \_\_\_\_\_

Yes ☐ No ☐ Date \_\_\_\_\_

Yes ☐ No ☐ Date \_\_\_\_\_

Yes ☐ No ☐ Date \_\_\_\_\_

☐
☐
☐
☐
☐
☐

**\*Trusts/Hospitals require written evidence of immunity to Rubella, Varicella and TB. Please provide this information**

Please enter any additional information below. If there is insufficient room please continue on another sheet.

I declare that the information provided on this form is correct to the best of my knowledge.

Signed \_\_\_\_\_

Date \_\_\_\_\_