



HEALTH AT WORK QUESTIONNAIRE

Confidential

Health Statement

Cotteswold Dairy Ltd is committed to providing a healthy and safe environment for our staff.

Work within our organisation involves many different activities and duties. This work may, at times, cause some physical strain and you should consider this when deciding whether you wish to work for us.

The purpose of this questionnaire is to help ensure that you will be able to do your job at Cotteswold Dairy Ltd without risk to yourself and others.

Your answers will be treated as **confidential** and will only be seen by interview personnel.

SURNAME: _____ Mr/Mrs/Miss/Ms

OTHER NAMES:

DATE OF BIRTH: _____

ADDRESS:

POSITION APPLIED FOR: _____

PLEASE READ THE DECLARATION AT THE END OF THIS QUESTIONNAIRE. YOU WILL NEED TO SIGN IT WHEN YOU HAVE ANSWERED ALL OF THE QUESTIONS. **PLEASE BRING THE COMPLETED QUESTIONNAIRE WITH YOU WHEN YOU ATTEND FOR INTERVIEW.**

Please circle 'Yes' or 'No' as appropriate.

Do you suffer from any of the following?

| | | | |
|--|--------|---------------------------------------|--------|
| Epilepsy | Yes/No | Repetitive strain injury | Yes/No |
| Heart Problems | Yes/No | Back Trouble | Yes/No |
| Fainting attacks, giddiness or blackouts | Yes/No | Deafness not corrected by hearing aid | Yes/No |
| Mental Illness | Yes/No | Diabetes (Insulin controlled) | Yes/No |
| Recurring chest problems | Yes/No | Asthma | Yes/No |
| Fits or blackouts | Yes/No | Neck trouble | Yes/No |
| Frequent headaches/Migraines | Yes/No | Other muscle or joint problems | Yes/No |
| Blood circulation problems | Yes/No | Defective eyesight | Yes/No |
| Skin Conditions | Yes/No | Re-occurring stomach/bowel complaints | Yes/No |

Do you smoke?

Yes/No

What is your consumption of alcohol per week?

Do you have any health problems affecting...

| | | | |
|------------------------|--------|---------|--------|
| Sitting | Yes/No | Lifting | Yes/No |
| Standing | Yes/No | Walking | Yes/No |
| Stairs/Ladder/Climbing | Yes/No | Bending | Yes/No |
| Use of Hands | Yes/No | | |

Food Hygiene History

(to be completed by food handlers e.g. Dairy operatives, Rounds persons, Laboratory staff)

Have you ever suffered from.....

| | | | |
|--------------------------|--------|------------------------------|--------|
| Typhoid | Yes/No | A running ear | Yes/No |
| Paratyphoid | Yes/No | Re-occurring chest complaint | |
| Re-occurring Ear Trouble | Yes/No | (i.e. cough/phlegm) | Yes/No |

At present, are you suffering from.....

| | |
|---------------------------------------|--------|
| A cough with phlegm | Yes/No |
| Acne, boils, sties' or septic fingers | Yes/No |
| Diarrhea, Stomach pain or fever | Yes/No |

If you have had any of these problems in the past, please give details and dates:

In the last 2 years, have you been off work because of illness or injury? Yes/No
If yes, how many working days did you lose and what was the reason?

Are you currently having any treatment or medicine prescribed by a doctor or taking self prescribed medicines or tablets? Yes/No
If yes, please give details

Are you on a waiting list for treatment or an operation? Yes/No
If yes, please give details

Are you currently under the care of a doctor or other medical professional? Yes/No
If yes, please give details

DECLARATION

I hereby declare that, to the best of my knowledge and belief, my answers to all these questions are complete, accurate and true and that I have not omitted any information relating to either my past or present state of health. I understand in the case of any false statement being made, this may affect any future contract with the company. I have read and understood the health statement on the first page of this questionnaire. All information will be retained under the provisions of the Data Protection Act 1998.

Signed: _____ Date: _____