THE QUEEN'S UNIVERSITY OF BELFAST
OCCUPATIONAL HEALTH DEPARTMENT

Office Use Only
_____
Student No _____
NMC Reg ☐
Date _____

CONFIDENTIAL HEALTH DECLARATION

PERSONAL DETAILS (please print)

Surname _____ First Name _____ Marital Status _____

Sex _____ Date of Birth _____ Health & Care No._____

Mailing Address (if known)

_____

_____

Postcode _____

E-mail _____

Telephone _____

Mobile _____

Next of Kin & Address

_____

_____

Postcode _____

Mobile/Telephone _____

Name of GP/Family Doctor & Address

_____

_____

_____

Please tick Yes/No to the following. If yes, give details.

	MEDICAL HISTORY	YES	NO	PLEASE PROVIDE DETAILS
1	Have you consulted your GP during the past 2 years?	☐	☐	_____
2	Have you received any injections, tablets or other treatment from a doctor in the past six months?	☐	☐	_____
3	Have you ever been admitted to/or treated at a hospital for any illness or accident?	☐	☐	_____

Do you suffer from, or have you ever suffered from, any of the following?

4	Migraine or recurrent headaches?	☐	☐	_____
5	Allergies, eg to antibiotics, nickel, latex/rubber or pollen	☐	☐	_____
6	Epilepsy, black outs or dizziness	☐	☐	_____
7	Serious head injury or loss of consciousness	☐	☐	_____
8	Asthma, bronchitis or other chest complaint	☐	☐	_____
9	Heart trouble, rheumatic fever, high blood pressure or poor circulation	☐	☐	_____
10	Gastric or duodenal ulcer or other digestive or bowel disorder	☐	☐	_____
11	Jaundice or any other liver disorder	☐	☐	_____
12	Dermatitis, eczema, dry sensitive skin or psoriasis	☐	☐	_____
13	Persistent skin or ear infections.	☐	☐	_____
14	Frequent sore throats or tonsillitis	☐	☐	_____

		YES	NO	PLEASE PROVIDE DETAILS
15	Depression, nervous disability, psychiatric problems or any other mental health problem	☐	☐	_____
16	Eating disorder: anorexia or bulimia	☐	☐	_____
17	Paralysis or other neurological disorders	☐	☐	_____
18	Any back trouble including slipped disc or bone problems	☐	☐	_____
19	Problems with standing, bending, lifting or other movements	☐	☐	_____
20	Problems with your hands, arms, legs or feet which affect full movement	☐	☐	_____
21	Blood disorders or illness affecting your immune system (including HIV or AIDS)	☐	☐	_____
22	Diabetes, thyroid or other gland problems	☐	☐	_____
23	Do you have any hearing difficulties?	☐	☐	_____
24	Do you wear glasses/contact lenses?	☐	☐	_____
25	Have you any form of colour blindness?	☐	☐	_____
26	Have you had a chest x-ray or ECG? If so, when and for what reason?	☐	☐	_____
27	Are you taking any regular medication?	☐	☐	_____
28	Have you ever been considered to have any form of dyslexia or learning disability?	☐	☐	_____
29	Have you any condition/disability for which the University may need to make allowance or adjustment?	☐	☐	_____

LIFESTYLE		YES	NO	DETAILS
1	Do you smoke? If yes, how many cigarettes daily?	☐	☐	_____
2	Do you drink alcohol? If yes, how many units of alcohol each week.	☐	☐	_____
3	Have you ever abused alcohol, drugs or other substances?	☐	☐	_____
4	Do you take regular exercise? If yes, give details	☐	☐	_____
5	Has your weight changed by more than 5kgs in the last year?	☐	☐	_____

INFECTIOUS DISEASE HISTORY

PHOTO

1 Have you ever had any of the following diseases If yes, give approximate dates	YES	NO	DETAILS
Measles	☐	☐	
Mumps	☐	☐	
Rubella (German Measles)	☐	☐	
Chickenpox	☐	☐	
Shingles	☐	☐	
Tuberculosis (TB)	☐	☐	
Hepatitis	☐	☐	
Thyphoid	☐	☐	
Dysentery	☐	☐	
Food Poisoning	☐	☐	

2 Do you have, or have you recently had:			
Persistent coughing?	☐	☐	
Coughing up blood?	☐	☐	
Unexplained weight loss?	☐	☐	
Unexplained fever?	☐	☐	
Night sweats?	☐	☐	

3 Have you been in close contact with anyone found to be suffering from TB?	☐	☐	_____
4 Have you lived/worked outside of the UK or Ireland, for 3 months or more, in the last five years?	☐	☐	_____

IMMUNISATION HISTORY

Have you ever had any of the following vaccinations or tests? Please complete giving dates.

Immunisation	Yes	No	Dates (most recent)	Test Results
Tetanus				
Poliomyelitis				
Diphtheria				
Rubella (German Measles)				
Rubella Titre (Test)				
MMR				
TB Test (Heaf, Tine, Mantoux)				
BCG (TB Vaccination)				
Meningitis A & C				
Meningitis C				
Typhoid				
Hepatitis A				
Hepatitis B Injection No 1 Injection No 2 Injection No 3 Blood Test (Titre) Booster Dose Blood Test (Titre)				

It is essential you upload records of your vaccinations.

If you have had vaccinations against Hepatitis B please send or forward any documentary evidence of your response to this vaccine.

You may have to contact your parents, doctor, school or previous employer for such records.

OCCUPATIONAL HEALTH

To enable us to organise your occupational health care please list previous jobs you have had and detail any specific hazards or health risks to which you were exposed, for example dust, fumes, noise.

From	To	Job Description	Employer	Hazards	Reason for Leaving

		YES	NO	DETAILS
1	Have you previously been medically examined for employment?	☐	☐	_____
2	Have you previously been medically rejected from employment?	☐	☐	_____
3	Have you ever had any other illness which you feel may be relevant to your employment?	☐	☐	_____

4 Have you had any illness/injury which has kept you from your usual activities whether these be work, domestic or leisure, for more than five days in the last two years? If yes, please give details below.

From	To	Reason for Absence

DECLARATION: BY SUBMITTING THIS FORM

I declare that the information I have given is true and complete to the best of my knowledge and belief.

I understand that failure to disclose information or giving false information may result in dismissal.

I understand that I may be required to attend a medical examination.

I consent to this information being made available to occupational health departments/clinical placement managers for health and safety purposes and to the University Disability Service, if necessary, for personal support.

Signature _____ Date _____