PRE-REGISTRATION HEALTH QUESTIONNAIRE
Please return to Occupational Health at the address below

Data Protection Information

If you join this University/School, this questionnaire will form the basis of your Occupational Health (OH) record. If you do not join, your questionnaire will be destroyed.

Records are held **in confidence** by the University Occupational Health Service, in line with the GMC's guidance on *Confidentiality*. The school will only be informed of the need to make adjustments if it is relevant to your educational needs or patients' safety and with your full involvement. Failure to declare a known medical condition or event may lead to withdrawal of your offer by the University.

You may obtain access to your OH record by contacting the OH Service (see below).
If you require further information contact the OH Service:

Staff & Student Occupational Health Service
University Medical Services
University Of East Anglia
Norwich, NR4 7TJ

Appointments: 01603 592174
Fax: 01603 506579
Email: ums.oh@nhs.net

Section 1: Personal Details

Family name: _____ Given name(s): _____

Date of birth: _____ Male/female/other: _____ Title (Mr, Ms, Mrs etc) _____

Contact address: _____ GP's name and address: _____

_____ _____

_____ _____

Tel: home _____ Tel: _____

Tel: mobile* _____ **We operate a text recall/reminder service. Please express your consent to this service:* ☐ *IN* ☐ *OUT*

Email: _____

Course applied for (please **tick** course you have applied for):

- ☐ Speech and Language Therapy
- ☐ Physiotherapy
- ☐ Pharmacy
- ☐ Operating Department Practitioner
- ☐ Occupational Therapy
- ☐ Nursing
- ☐ Midwifery
- ☐ Paramedic
- ☐ Medicine (A100 – 5 yr course)
- ☐ Medicine (A104 – 6 yr course)
- ☐ Physician's Associate

Course title:

_____

_____

Start date of course:

_____

Please write your area of study on Page 4 – Doctor's Certificate and your name on every sheet (top right hand corner)

Name……

****Please ensure your doctor completes and signs page 4****

You are required to inform Occupational Health if there is any change in your health between completing the questionnaire and starting at UEA.

Section 2: Providing reasonable adjustments

In order to help us plan to make reasonable adjustments please supply the following information.

1. Do any of the following present you with difficulty?

- **Mobility** e.g. walking, using stairs, driving, sitting for long periods Yes ☐ No ☐
- **Agility** e.g. bending, reaching up, kneeling down, maintaining balance Yes ☐ No ☐
- **Dexterity** e.g. writing, using tools Yes ☐ No ☐
- **Physical exertion** e.g. lifting, carrying Yes ☐ No ☐
- **Communication** e.g. speech Yes ☐ No ☐
- **Hearing** e.g. deaf, hard of hearing, tinnitus Yes ☐ No ☐
- **Vision** e.g. blind, visual impairment, colour blindness, tunnel vision Yes ☐ No ☐
- **Learning** e.g. dyslexia, dyspraxia, dyscalculia, impaired concentration Yes ☐ No ☐

*If **yes** to any of the above, give details e.g. extent of impairment, any support needs or course adjustments required.*

2. Have you ever required special arrangements at school, college or work to overcome barriers, e.g. equipment, extra time in exams, part-time working? Yes ☐ No ☐
*If **yes**, give details*

3. Do you have any of the following:

- **Chronic skin conditions** e.g. eczema, psoriasis Yes ☐ No ☐
- **Neurological disorder** e.g. migraines, epilepsy, multiple sclerosis Yes ☐ No ☐
- **Allergies** e.g. to latex, medicines, foods Yes ☐ No ☐
- **Endocrine disease** e.g. diabetes Yes ☐ No ☐

If yes to any of the above, give details (e.g. when condition developed, severity, treatment and course adjustments required).

Name……..……

4. Have you ever **been affected by:**

- **Sudden loss of consciousness** e.g. a fit or seizure Yes ☐ No ☐
- **Chronic fatigue syndrome** (or similar condition) Yes ☐ No ☐
- **An illness requiring more than 2 weeks absence from school/work?** Yes ☐ No ☐
- Anxiety, depression, overdose, self-harm, phobias, psychosis, obsessive-compulsive disorder (OCD), nervous breakdown, personality disorder, drug/alcohol dependency Yes ☐ No ☐
- **An eating disorder** e.g. bulimia, anorexia nervosa, compulsive eating Yes ☐ No ☐

*If **yes** to any of the above, give details e.g. when condition developed, effects, treatment and course/work adjustments required.*

5. Have you ever consulted with or been assessed or treated by a psychiatrist, psychotherapist or counsellor with regards to any personal issues? Yes ☐ No ☐

*If **yes** give details e.g. when, reason, outcome.*

6. Are you currently taking any medication or treatment? Yes ☐ No ☐

7. Do you have any impairment or health condition not already mentioned for which you think you may require support or adjustments during your education or training?

*If **yes** to either of the above**,** give details.* Yes ☐ No ☐

8. What is your height? …….. metres What is your weight? …….. kg

9. How many days off due to sickness have you had in the past 2 years, and on how many occasions?

…….. day(s) on …….. occasion(s)

Section 3: Declaration

Please tick the relevant boxes and sign below

☐ The information I have provided on my impairment or health condition is **correct** and complete to the best of my knowledge and belief

☐ I consent to my information being held and processed by the OH Service as described above under 'Data Protection Information'

Signed…….. **Date** ……..

Name……..……

Section 4: Doctor's Certificate

Your patient has been offered a place to study ……..……at the University of East Anglia (UEA). All prospective healthcare students are required to complete a health questionnaire to help the school plan to meet any requirements for disabled students, make reasonable adjustments to the course to ensure that the applicant will be able to undertake the course successfully, and to ensure that the student is fit, on health grounds, to work with patients and practise after qualification.

We are not asking you for your opinion about their competence to practise, as this will be assessed during the course. However, we do require an applicant's doctor to verify the impairment/disability and health information provided by applicants on the basis of their knowledge of the patient.

1. Are you the applicant's usual doctor? Yes ☐ No ☐

2. Are you a relative of the applicant? Yes ☐ No ☐

3. Do you hold the applicant's medical record? Yes ☐ No ☐

4. Is the record complete? Please give details of any deficiencies Yes ☐ No ☐

5. According to your records and knowledge of the applicant, do the answers to questions in Section 2 appear complete and correct? Yes ☐ No ☐
Please add any comments below, if appropriate:

6. Are you aware of any additional medical information which may be relevant to this application? Yes ☐ No ☐
If yes please provide details.

****PLEASE ATTACH AN UP TO DATE IMMUNISATION HISTORY FOR THIS PATIENT****

PLEASE NOTE. A medical examination is not required. Any fee required for completion of the form is the responsibility of the patient.

Doctor's Signature ……..

Date ……..

Practice Stamp

****Please ensure your doctor completes and signs this page****