Pre-Employment Medical Evaluation Questionnaire

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 University 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 Dr McGrath, Director, at the College Health Centre via the email address above.

General Information

Name	
Address	
Telephone – Home	
Telephone - Mobile	
Email	
Date of Birth	
Gender	
Nationality:	
Full Title of Position Appointed to:	
Discipline/ Department appointed to:	

Please provide brief information on duties / working environment appointed to (i.e. manual handling, chemicals, materials etc.)	
Name and Contact Details of Current Doctor	

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		Please explain
Good		
Fair		
Poor		

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

Yes		If yes, please specify:
No		

1.3 Do you smoke?

Yes		If yes, please specify quantity smoked per day:
No		

1.4 Do you drink alcohol?

Yes		If yes, please quantity your weekly intake:
No		

1.5 Do you take non-prescription drugs regularly?

Yes		If yes, please specify:
No		

1.6 Do you take prescription drugs regularly?

Yes		If yes, please specify:
No		

1.7 Do you use recreational drugs?

Yes		If yes, please specify:
No		

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

Yes		If yes, please specify:
No		

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

Yes		If yes, please indicate the nature of the problem:
No		

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		If yes, please specify:
No		

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

	Yes	No
Standing		
Walking		
Lifting		
Bending		
Moving your neck or back		
Using your hands or elbows		
Working at heights		
Climbing stairs		

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		If yes, please specify:
No		

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

Yes		If yes, please specify:
No		

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

Yes		If yes, please specify:
No		

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

Yes		If yes, please specify:
No		

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

Yes		If yes, please specify:
No		

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:

	Yes	No	If so, please provide details:
Chemicals?			
Excessive dust?			
High levels of noise?			

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

	yes	no	Please specify
Lung/chest problems? *e.g. asthma, TB, pneumonia, bronchitis*			
Heart problems or circulatory disorders? *e.g. heart murmur, heart attack, high blood pressure*			
Stomach/bowel/liver/gallbladder or pancreatic problems?			
Kidney disorder? *e.g. Kidney stones/infections or kidney failure?*			
Glandular problems? *e.g. diabetes or thyroid problem*			
Disorders of the nervous system? e.*g. fits, blackouts, migraine, epilepsy, stroke*			
Psychiatric or mental health problems? *e.g. anxiety, depression, nervous breakdown, anorexia or attendance with a psychiatrist*			
Have you ever suffered from a fatigue syndrome? *e.g. post viral fatigue, M.E., burnout etc.*			
Eyes, ears, nose or throat problems?			
Sexually transmitted or tropical diseases?			
Skin problems? *e.g. moles, eczema, dermatitis, psoriasis*			
Tumours – benign or malignant?			
Have you ever had an operation?			
Have you any allergies?			
Have you ever had any gynaecological problems?			

	yes	no	Please specify
Any other accidents, illness or injuries?			
Neck or back trouble? *e.g. muscular problems, whiplash, disc prolapse*			
Arthritis, joint problems, gout?			
Work Related Upper Limb Disorder (WRULD) or Repetitive Strain Injury (RSI), tendonitis?			

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		If yes, please specify:
No		

3.2 Buzzing noises (tinnitus) in your ears?

Yes		If yes, please specify:
No		

3.3 The feeling that people were not speaking clearly?

Yes		If yes, please specify:
No		

3.4 Difficulty hearing people in a crowded room?

Yes		If yes, please specify:
No		

3.5 Family history of deafness?

Yes		If yes, please specify:
No		

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

Yes		If yes, please specify:
No		

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

Yes		If yes, please specify:
No		

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

Yes		If yes, please specify:
No		

3.9 Have you ever word hearing protection at work?

Yes		If yes, please specify:
No		

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

Yes		If yes, please specify:
No		

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 Human Resources 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 University 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 _____