PRE-EMPLOYMENT HEALTH QUESTIONNAIRE
(Non-clinical) North Haven Hospice

Please complete all pages & sign last page. Return the form:

Office Use only
Date Received:
Date to IC&P:

Rhonda Kaire
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NEW ZEALAND
Phone: (64) 09 437 3355
Fax: (64) 09 437 6219 **or** *Email: rhondak@northhavenhospice.org.nz*

Please answer yes or no questions with a tick ☑. Provide details for Yes answer.
If any part of the questionnaire is unclear, please contact North Haven Hospice (NHH).

Surname: (Dr/Mr/Mrs/Miss/Ms): *(previously known as)*	
First Name/s:	Male / Female
Date of Birth:	NHI: (*if known*)
Postal Address:	
Email Address:	
Home Telephone No:	Cell Phone No:
Position Applied for:	Department/Unit:
Manager:	Planned Start Date:
Currently working/previously worked at NHH YES ☐ NO ☐	
Contracted Hours Full Time ☐ Part Time ☐ Part Time no Fixed Hours (casual) ☐	
Permanent Contract ☐ Short Term Contract ☐ Finishing Date:	

On receipt of this completed questionnaire NHH initiate an assessment process, usually taking 5-7 working days to completion. Further requirements will be advised by NHH. Please note: Costs incurred if you use outside agencies (not NHH) are your responsibility.

Your personal medical information is treated in the strictest confidence and will be reviewed by a competent person. Information is collected and stored in accordance with the Privacy Act 1993 and the Health Information Privacy Code 1994. Information will not be disclosed to a third party without your consent.

The Health and Safety at Work Act (2015) requires employers to ensure the health and safety of employees and others while at work. Your information is therefore used by NHH to:

- identify and record your baseline health status
- assess your fitness and suitability for work
- identify safe work activities, workplace modifications or risks
- assist in managing hazards and risks

A. GENERAL HEALTH	Yes	No
In the last 2 years have you had more than five days off work due to a health issue? ***Details:***		

Please list **current medications**:

Tick if you have or **ever** have had:

- Hepatitis
- Heart disease/angina/stroke
- Bronchiectasis
- Asthma
- Migraine headaches
- Dermatitis/eczema
- Tuberculosis
- Cancer
- Hernias
- Arthritis, fibromyalgia, gout
- Hearing/ear disorders
- Mental health illness i.e. depression
- Vision/eye disorder
- Immune disorder
- Epilepsy
- Lung condition
- Head/brain injury/condition

Details:

Do you have allergies e.g. latex, food, insect bites or medicine, animal's chemicals etc.?

Yes ☐ No ☐

Details:

Are you currently seeking medical advice, receiving treatment or having investigations? Yes ☐ No ☐

Details:

B. MUSCULOSKELETAL HEALTH (Bones, muscles, tendons, joints, ligaments etc.)	Yes	No
Have you **ever** had a sprain, strain or fracture which has affected your ability to work?		
Within the last 5 years, have you been reviewed/treated for an injury or musculoskeletal condition by a Doctor, Physiotherapist, Acupuncturist, Chiropractor, Osteopath, Orthopaedic, Occupational, Neurologist or Musculoskeletal specialist? Or another specialist?		
Do you have any residual problems from previous injuries that may affect your ability to work or undertake physical work?		

Details:

C. MENTAL HEALTH	Yes	No
Within the last 5 years, have you been reviewed/treated for depression, post-traumatic stress disorder, anxiety disorder, or any other mental health condition?		

What was required to help you maintain your normal work?

Are you currently having therapy and/or medication?		

Details:

D. HEARING HEALTH	Yes	No
Have you previously worked in a noisy environment?		
If yes, please specify employers name: …….		
Did you routinely wear hearing protection?		
Have you ever had a hearing test (audiogram)?		
Date of most recent test: *(please supply copy of results)*		
Describe times when you have difficulty hearing –		

E. VISUAL HEALTH	Yes	No
Have you had any problems with your vision in the past 3 months?		
Do you need to wear glasses or lenses of any sort to help you see clearly or perform your work?		
Details:		

F. ADDICTIONS	Yes	No
Have you or do you use illegal substances		
Have you **ever** suffered adverse consequences from alcohol, cannabis, or other drug use?		
Were there any physical, financial, court related, or negative work consequences?		
Details:		

G. HAZARDOUS SUBSTANCE EXPOSURE	Yes	No
Have you **ever** had any health problems related to contact with or exposure to chemicals, fumes, solvents, skin irritants, ionising radiation, asbestos or dust?		
Substance involved*:* ……Resulting health problems? ***Details:***		

H. OTHER

North Haven Hospice buildings and grounds are smoke free.

Do you **smoke tobacco**? Yes ☐ No ☐

If yes, would you like to participate in a **Smoking Cessation Programme**? Yes ☐ No ☐

Do you have **a disability or** any other health issues (not covered elsewhere in this form) that may affect your ability to work *or* to take part in training? Yes ☐ No ☐

Details:

Do you require any **workplace modifications** to adequately perform the job offered? Yes ☐ No ☐

Details:

Do you have any previous or ongoing ACC claims? ? Yes ☐ No ☐
Details:

In your prospective job you may be required to do the following. Please tick those that are or may be an issue for you.

☐ work a full day or shift	☐ bend
☐ walk/stand/sit	☐ lean over
☐ make self-safe in an emergency	☐ crouch
☐ reach above shoulder height	☐ kneel
☐ use arms above shoulder height	☐ crawl
☐ provide patient assistance	☐ grip
☐ use hand tools or instruments	☐ carry
☐ work at a computer	☐ lift
☐ drive a vehicle	☐ push
☐ hear/speak to communicate	☐ pull

Details:

	DECLARATION AND CONSENTS
☐	I declare to the best of my knowledge that the information I have given in this questionnaire is correct, true, complete and accurate and I have not omitted any information, or provided misleading information. I understand that giving false or misleading information or suppressing information will be construed as misconduct and disciplinary action may be taken against me if I am employed by NHH.
☐	I consent to this information being used by NHH to make decisions regarding my employment and for ongoing monitoring of the hazards and risks that I will be exposed to while employed by NHH.
☐	I consent to NHH contacting my GP for relevant information as required.

Name: (print) ……..	**Signature:** ……