

**PRE-EMPLOYMENT HEALTH QUESTIONNAIRE**  
**(Non-clinical) North Haven Hospice**  
**Please complete all pages & sign last page. Return the form:**

<b>Office Use only</b> Date Received: Date to IC&P:
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 NEW ZEALAND  
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**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):		<i>(previously known as)</i>	
First Name/s:			Male / Female
Date of Birth:	NHI: <i>(if known)</i>		
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 <input type="checkbox"/> NO <input type="checkbox"/>			
Contracted Hours    Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Part Time no Fixed Hours (casual) <input type="checkbox"/>			
Permanent Contract <input type="checkbox"/> Short Term Contract <input type="checkbox"/> 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? <u>Details:</u>		
Please list <u>current medications</u> :		
Tick if you have or <b>ever</b> have had: <ul style="list-style-type: none"> <li><input type="checkbox"/> Hepatitis</li> <li><input type="checkbox"/> Heart disease/angina/stroke</li> <li><input type="checkbox"/> Bronchiectasis</li> <li><input type="checkbox"/> Asthma</li> <li><input type="checkbox"/> Migraine headaches</li> <li><input type="checkbox"/> Dermatitis/eczema</li> <li><input type="checkbox"/> Tuberculosis</li> <li><input type="checkbox"/> Cancer</li> <li><input type="checkbox"/> Hernias</li> <li><input type="checkbox"/> Arthritis, fibromyalgia, gout</li> <li><input type="checkbox"/> Hearing/ear disorders</li> <li><input type="checkbox"/> Mental health illness i.e. depression</li> <li><input type="checkbox"/> Vision/eye disorder</li> <li><input type="checkbox"/> Immune disorder</li> <li><input type="checkbox"/> Epilepsy</li> <li><input type="checkbox"/> Lung condition</li> <li><input type="checkbox"/> Head/brain injury/condition</li> </ul> <u>Details:</u>		
Do you have allergies e.g. latex, food, insect bites or medicine, animal's chemicals etc.? Yes <input type="checkbox"/> No <input type="checkbox"/> <u>Details:</u>		
Are you currently seeking medical advice, receiving treatment or having investigations? Yes <input type="checkbox"/> No <input type="checkbox"/> <u>Details:</u>		
B. MUSCULOSKELETAL HEALTH (Bones, muscles, tendons, joints, ligaments etc.)	Yes	No
Have you <b>ever</b> 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?		
<u>Details:</u>		
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? <u>Details:</u>		



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.

- |                                                         |                                    |
|---------------------------------------------------------|------------------------------------|
| <input type="checkbox"/> work a full day or shift       | <input type="checkbox"/> bend      |
| <input type="checkbox"/> walk/stand/sit                 | <input type="checkbox"/> lean over |
| <input type="checkbox"/> make self-safe in an emergency | <input type="checkbox"/> crouch    |
| <input type="checkbox"/> reach above shoulder height    | <input type="checkbox"/> kneel     |
| <input type="checkbox"/> use arms above shoulder height | <input type="checkbox"/> crawl     |
| <input type="checkbox"/> provide patient assistance     | <input type="checkbox"/> grip      |
| <input type="checkbox"/> use hand tools or instruments  | <input type="checkbox"/> carry     |
| <input type="checkbox"/> work at a computer             | <input type="checkbox"/> lift      |
| <input type="checkbox"/> drive a vehicle                | <input type="checkbox"/> push      |
| <input type="checkbox"/> hear/speak to communicate      | <input type="checkbox"/> 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)**

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**Signature:** .....