



STRICTLY PRIVATE & CONFIDENTIAL MEDICAL QUESTIONNAIRE FOR VDU USERS

PLEASE ANSWER ALL QUESTIONS FULLY, WITH YES OR NO ANSWERS WHERE APPROPRIATE. IF YES, PLEASE GIVE DETAILS.

NAME:

POSITION APPLIED FOR:

DATE:

GENERAL INFORMATION

Date of birth:	Number of years using a VDU screen:
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GENERAL MEDICAL HISTORY

1 How would you describe your health?

<i>Excellent</i>	<i>Very Good</i>	<i>Good</i>	<i>Fairly Good</i>	<i>Poor</i>
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2 Do you suffer from any of the following?

CONDITION	DETAILS
Skin rashes/redness	
Stomach/digestive disorders	
Fatigue/stress	

3 Have you consulted a doctor about these?

In the past year?	In the past 5 years?
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SKELETAL HISTORY

- 1 Do you suffer from any aches, pains or sensory loss (tingling, pins and needles) in any of the following?

AREA AFFECTED	DETAILS
Neck	
Back	
Shoulders	
Upper limbs	
Wrists	
Fingers	
Legs	

- 2 Have you ever experienced any of the following?

CONDITION	DETAILS
Restricted joint movement	
Impaired finger movement	
Impaired finger grip	

- 3 Have you ever consulted a doctor or had treatment for any of the conditions named in questions 1 and 2 above?

VISION HISTORY

1 Do you suffer with any of the following?

CONDITION	DETAILS
Focusing difficulties	
Headaches	
Eye discomfort	
Difficulty in seeing	
Any other vision problems	

2 Have you ever consulted a doctor or had treatment for any of these?

In the past year?	In the past 5 years?
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3 Do you wear spectacles?

YES / NO

4 Do you wear contact lenses?

YES / NO

DECLARATION

The information provided herewith will be used for health and safety purposes and may be used, with your consent, to obtain further medical evidence. If you are unsuccessful in your application the information will be kept for a period of no longer than four months from the date you are informed of this decision. By signing the declaration below you are consenting to the aforesaid use of the information being stored and monitored for the purpose of our equal opportunities policy.

I declare that to the best of my knowledge and belief, the statements made in connection with this medical form are true and that I have not withheld any material facts.

Signed:	Date:
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