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**NOTTINGHAMSHIRE  
POLICE**

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## MEDICAL HISTORY QUESTIONNAIRE

**CONFIDENTIAL WHEN COMPLETED**



**-RESTRICTED-  
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**MEDICAL HISTORY  
QUESTIONNAIRE**

For official use only Candidate number
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**CONFIDENTIAL (WHEN COMPLETED)**

Our health standard requires you to show that you can give regular and effective service. In order to do this, we ask you to provide details of your health. Do not be concerned if you find yourself answering 'Yes' to a lot of questions. This is quite normal and does not mean that you are unfit for the job. We will contact you if we need further details and, if necessary, ask for a report from your GP. The health of each candidate is considered individually and no decision to reject a candidate is made without referral to a medical advisor.

If you successfully pass the assessment centre stage of the recruitment process, you will be asked to complete this form and take it to your GP for confirmation. Once your GP has signed the form, send it to the occupational health unit of the force you are applying to in the envelope supplied. **Please keep a copy of your form.**

You will then be invited to attend a medical examination or referred to your GP for a medical examination.

The information given on this form and at subsequent medical examinations will also be used to form an opinion of whether you are at risk of early ill-health retirement. If you do not wish to know the outcome of that assessment you can ask for it to be withheld unless you subsequently decide to appeal against the decision.

Please note that you will be required to sign a declaration at the end of this form and it is important that your answers are accurate and you do not withhold any information. We are an equal opportunities employer and recruit on the basis of ability not perceived disability. Any information given on your medical history on any disability will assist us in assessing whether reasonable adjustments can be made.

<b>Your details</b>	
Surname:	Forename(s):
Date of birth:	Male / female (delete as appropriate):
Full postal address including postcode:	
Telephone:	

<b>General Practitioner's Details</b>	
Name:	Telephone Number:
Full postal address including postcode:	

**-RESTRICTED-  
NOTTINGHAMSHIRE POLICE**

Please answer ALL the following questions. If you answer YES to any of the conditions, you will need to give details on page 5 including the appropriate medical condition number. If you have any questions, contact your local recruitment office for advice or for referral to the Occupational Health Unit.

The Disability Discrimination Act 1995 defines a person with a disability as “A physical or mental impairment which has a substantial adverse long term effect on his or her ability to carry out normal day to day activities.”

Do you have a disability which may affect your ability to undertake the role of police constable or which requires special arrangements? Yes  No

If yes, what facilities/adjustments/equipment might enable you to perform the role?

<b>Medical Conditions</b>	
You are asked to indicate whether you currently have or have ever had any of the following medical conditions.	
<b>1</b>	Epilepsy, fits, blackouts, fainting turns or unexplained loss of consciousness <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
<b>2</b>	Head injuries leading to loss of consciousness requiring hospital admission <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
<b>3</b>	Recurrent headache or migraine <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
<b>4</b>	Diseases of the nervous system e.g. neuritis, stroke, multiple sclerosis <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
<b>5</b>	Injury or surgery to your eye(s) including laser eye surgery or any other type of refractive surgery <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
<b>6</b>	Any visual defect e.g. scotoma, blindness in one eye, night blindness, colour blindness, reduced visual field, blurred vision or detached retina <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
<b>7</b>	Any eye disease or conditions such as glaucoma or retinitis pigmentosa <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
<b>8</b>	Ear infection, discharge, tinnitus, a hearing defect including deafness <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
<b>9</b>	Vertigo, dizziness, giddiness, problems with balance <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
<b>10</b>	Chest pain, angina, heart disease or breathlessness <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
<b>11</b>	Varicose veins or circulation problems <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
<b>12</b>	Rheumatic fever <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
<b>13</b>	Raised or low blood pressure <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
<b>14</b>	Any blood disorder <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
<b>15</b>	Asthma, bronchitis, emphysema, pleurisy, pneumonia or any other lung disease including TB or pneumothorax disorder <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
<b>16</b>	Recurrent nausea, dyspepsia, heartburn, indigestion or hiatus hernia <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
<b>17</b>	Gastric, duodenal or peptic ulcer <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
<b>18</b>	Inflammation of the bowel including Crohn's Disease, ulcerative colitis, bleeding from rectum or diarrhoea lasting more than one week <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
<b>19</b>	Irritable bowel syndrome <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>

**-RESTRICTED-  
NOTTINGHAMSHIRE POLICE**

<b>Medical Conditions</b>	
Jaundice or any form of hepatitis or other liver problem	Yes <input type="checkbox"/> No <input type="checkbox"/>
Any other abdominal complaint including hernia	Yes <input type="checkbox"/> No <input type="checkbox"/>
Kidney stones	Yes <input type="checkbox"/> No <input type="checkbox"/>
Recurrent kidney or urinary tract infection e.g. cystitis and urethritis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Blood in urine	Yes <input type="checkbox"/> No <input type="checkbox"/>
Any other kidney or bladder conditions	Yes <input type="checkbox"/> No <input type="checkbox"/>
Any problems with bones or joints including back, neck, knee, sciatica, any fracture, or recurrent dislocation of a major joint	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you ever consulted an orthopaedic surgeon, chiropractor, osteopath or physiotherapist?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you been diagnosed as having arthritis, gout, chondromalacia patellae or rheumatism?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Psoriasis, eczema, allergic skin rash or other skin disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Any metabolic disorder including diabetes, thyroid and adrenal gland disease or other glandular disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>
Any disorders of reproductive organs including gynaecological, testicular and breast problems	Yes <input type="checkbox"/> No <input type="checkbox"/>
Any infectious diseases (apart from childhood illnesses) including sexually transmitted disease or tropical disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Anxiety/depression, phobias, mental breakdown or stress related problems	Yes <input type="checkbox"/> No <input type="checkbox"/>
Any other mental illness	Yes <input type="checkbox"/> No <input type="checkbox"/>
Any eating disorder e.g. anorexia nervosa or bulimia	Yes <input type="checkbox"/> No <input type="checkbox"/>
Substance misuse (e.g. drugs, steroids)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Any allergies including hayfever	Yes <input type="checkbox"/> No <input type="checkbox"/>
Any operations or surgical procedures	Yes <input type="checkbox"/> No <input type="checkbox"/>
Any malignancies or cancers	Yes <input type="checkbox"/> No <input type="checkbox"/>
Any unexplained weight loss in past year	Yes <input type="checkbox"/> No <input type="checkbox"/>
Current treatment. Are you currently attending a hospital/GP for treatment or waiting for an appointment?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If you have ticked 'Yes' to any of the above, please give details in the space provided on page 5. This will help the Occupational Health Unit to clarify the significance or otherwise of a 'Yes' answer. Please ensure that you quote the correct medical condition number.	

**-RESTRICTED-  
NOTTINGHAMSHIRE POLICE**

**Details of Medical Conditions**

Please include date(s) of illness/conditions, frequency, duration, what treatment was given and by whom (e.g. hospital/GP), whether you are still undergoing treatment and length of absence from work/school (if appropriate). Continue on a separate sheet if required.

<b>Medical Condition Number (see table on pages 3 and 4)</b>	<b>Details</b>

**Family History**

Is there a family history of a congenital condition (e.g. heart disease, strokes, nervous or mental disease)? If YES please give details and relationship

<b>Height (metres)</b>	<b>Weight (kgs)</b>

**-RESTRICTED-  
NOTTINGHAMSHIRE POLICE**

**Alcohol History**

How much alcohol on average do you consume over a seven day period?  
Units per week 1 unit = 1/2 pint beer = 1 glass of wine = 1 measure of spirits

**Past Medical History**

Have you ever failed a medical examination (or had special conditions imposed) for any employment reasons (including police service and HM Forces) or life assurance? If YES, please provide details.

Yes  No

Have you previously been notified that you would not be eligible for ill health benefits if appointed to the police service? If YES, please provide details.

Yes  No

Have you ever left a job or had to be medically retired due to ill health? If YES, please provide details.

Yes  No

Has any previous occupation caused you health problems? If YES, please provide details.

Yes  No

Are you in receipt of a medical pension or other disability benefit? If YES, please provide details.

Yes  No

