

Health Declaration

Surname:	Forenames:	Mr Mrs Ms / Miss	Oli-Office Number:								
Address: Post Code:		National Insurance Number:									
		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 12.5%; height: 20px;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>									
		Nationality:									
Sex? (please circle) Male Female											
		Date of Birth:									

How many units of alcohol do you drink each week?		How much tobacco do you smoke Per day?	
Are you disabled?	Yes/No	Registered disability number:	
Have you ever had an X-Ray	Yes/No	Date of last Chest x-ray:	
Do you wear glasses or contact lenses	Yes/No	Date of last sight test:	
Have you ever had a hearing test	Yes/No	Date of last hearing test:	
Please give details of any medication you are taking or any treatment you are undergoing:			

HAVE YOU EVER HAD OR SUFFERED FROM ANY OF THE FOLLOWING

Migraine	Yes/No	Hearing Problems	Yes/No
Recurring Headaches	Yes/No	Vertigo	Yes/No
Concussion	Yes/No	Chest Diseases	Yes/No
Fits or Epilepsy	Yes/No	Work related upper limb disorder	Yes/No
Dizzy Spells or Fainting	Yes/No	Hay Fever	Yes/No
High Blood Pressure	Yes/No	Skin Conditions	Yes/No
Back Injury	Yes/No	Rheumatic Fever	Yes/No
Diabetes	Yes/No	Allergies	Yes/No
Fibrositis	Yes/No	Heart Condition	Yes/No
Varicose Veins or Piles	Yes/No	Hepatitis	Yes/No
Gastric Conditions: Stomach or Duodenal Ulcer	Yes/No	Hernias	Yes/No
Eye Trouble or Colour Blindness	Yes/No	Any medical reason for being unfit for work for more than 2 weeks	Yes/No
Any Industrial Injury Requiring Medical Treatment	Yes/No	Any industrial disease needing medical treatment	Yes/No
Please give full details if you have answered yes to any of the above:			

Please give the name and address of your GP:

Please give dates that you were vaccinated against the following diseases:

Hepatitis B:_____ Serum Level:_____

Tetanus:_____ Poliomyelitis:_____ Rubella:_____ TB:_____

DECLARATION:

I declare that all the above is true to the best of my knowledge.

By signing this declaration it will permit us to approach you to sign for release of medical records if required.

Name: _____ Signed: _____ Date: _____

Please Return Application Forms to:

Knightwood Nursing Services
Knightwood Court
Mead Road
Stoke Gifford
Bristol
BS34 8PS
Tel: 01454 777715