



Medical History Questionnaire
Job Role:

Probationer Constable
Police Service of Northern Ireland

Introduction

The current PSNI health assessment standards reflect fitness for work at the time of your assessment. The information you provide is used to assess your eligibility for the post and entrance to the pension scheme in certain roles if applicable. Your application will be assessed in terms of ability based on the role functions and activities as set out in the PSNI Role Profile for the post.

It is essential that you provide as much detail as possible about any health conditions that you have experienced. In this questionnaire where you have ticked yes in any section, you must **also** provide as much detail as possible in the Comments Box, and where appropriate attach additional information so that all relevant health information can be considered.

PSNI will consider what measures could be **reasonably undertaken** to assist an applicant with a disability to undertake the role in keeping with their responsibilities under the Disability Discrimination Act 1995. To be considered capable of carrying out the specified role you must be able to undertake the duties as set out in the Role Profile. However there is no expectation that people who cannot fulfil the role will be recruited.

Guidance for Completion – please read these instructions carefully

Please note that you will be required to sign a declaration at the end of this form and it is therefore important that your answers are accurate and you do not withhold any information. It is essential that this document is a true representation of your health record.

In order to help you, we have divided the questionnaire into 3 sections. You, the candidate, must complete SECTIONS A and B and your General Practitioner should complete SECTION C.

SECTION A

If you tick yes to any question numbered 1 – 50 in SECTION A you must complete the Comments Box by referring to questions A-H. In addition, you should consider if you have 'additional information' to support your comments. Useful information includes letters, reports or test results from your General Practitioner (GP), hospital based specialists or paramedical specialists, e.g., Psychologist, Physiotherapist or other relevant treating practitioners. **You should attach this information to your questionnaire and bring it with you on the day of your medical examination.**

SECTION B

If you tick yes in any part of SECTION B you must complete the Comments Box.

SECTION C

This is for your GP to complete in full, sign and then verify with a Practice stamp.

All your information remains entirely confidential to the Occupational Health and Welfare Unit at PSNI.

Candidate Details:

UID Number:	
Date of Birth:	
First Name:	
Last Name:	
Address:	
Postcode:	
Gender:	Male / Female (Delete as appropriate)
Home Telephone No:	
Daytime Telephone No:	
Mobile Telephone No:	

General Practitioner Details:

Name:	
Address:	
Postcode:	

Now complete SECTION A and B before taking this questionnaire to your GP who must complete SECTION C.

IT IS VITAL SECTIONS A AND B OF YOUR QUESTIONNAIRE ARE COMPLETED, SIGNED AND DATED BY YOU BEFORE GIVING IT TO YOUR GENERAL PRACTITIONER TO COMPLETE SECTION C. FAILURE TO DO SO WILL RESULT IN A DELAY TO YOUR ASSESSMENT.

SECTION A

You must answer ALL questions below. If you answer **YES** to any of the questions numbered 1 - 50 then you must give as much information as possible in the Comments Box provided **and answer** questions A-G. *In addition you should consider if you have 'additional information' to support your comments. Useful information includes letters, reports or test results from your GP, hospital based specialists or registered health care professionals, e.g., Psychologist, Physiotherapist, Nurse, or other relevant treating practitioners and current Occupational Health provider. **You should attach this information to your questionnaire and bring it with you on the day of your medical examination.***

Eyes, eyesight and related conditions

	Have you had any past or current history of the following?	Yes	No
1	Any difficulties with your eyesight which is not correctable with basic glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
2	Injury or surgery to your eye(s) including Laser Eye surgery or any other type of refractive surgery?	<input type="checkbox"/>	<input type="checkbox"/>
3	Eye disease or conditions e.g. glaucoma, retinitis pigmentosa or detached retina?	<input type="checkbox"/>	<input type="checkbox"/>
4	Any visual defect including night blindness, loss of vision in one eye, blurred vision, reduced visual fields, and colour blindness?	<input type="checkbox"/>	<input type="checkbox"/>

Hearing, speech and related conditions

	Have you had any past or current history of the following?	Yes	No
5	A hearing defect including deafness?	<input type="checkbox"/>	<input type="checkbox"/>
6	Any ear infection, discharge, or tinnitus i.e. 'ringing' or noises in your ear(s)?	<input type="checkbox"/>	<input type="checkbox"/>
7	Any vertigo, dizziness, problems with your balance?	<input type="checkbox"/>	<input type="checkbox"/>
8	A speech impairment?	<input type="checkbox"/>	<input type="checkbox"/>

Cardiovascular

	Have you had any past or current history of the following?	Yes	No
9	Chest pain, angina, heart disease or breathlessness?	<input type="checkbox"/>	<input type="checkbox"/>
10	Varicose veins or circulation problems?	<input type="checkbox"/>	<input type="checkbox"/>
11	Rheumatic fever or heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
12	Raised or low blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>

Neurological

	Have you had any past or current history of the following?	Yes	No
13	Epilepsy, fits, blackouts, fainting turns or unexplained loss of consciousness?	<input type="checkbox"/>	<input type="checkbox"/>
14	Head injuries leading to loss of consciousness requiring hospital admission?	<input type="checkbox"/>	<input type="checkbox"/>
15	Recurrent headache or migraine?	<input type="checkbox"/>	<input type="checkbox"/>
16	Diseases of the nervous system e.g. neuritis, stroke, multiple sclerosis?	<input type="checkbox"/>	<input type="checkbox"/>

Metabolic

	Have you had any past or current history of the following?	Yes	No
17	Any metabolic disorder including Diabetes, Thyroid, Adrenal or Pituitary Gland disease or other glandular disorder?	<input type="checkbox"/>	<input type="checkbox"/>

Gastro-Intestinal

	Have you had any past or current history of the following?	Yes	No
18	Recurrent nausea, dyspepsia, heartburn, indigestion or hiatus hernia?	<input type="checkbox"/>	<input type="checkbox"/>
19	Gastric, duodenal or peptic ulcer?	<input type="checkbox"/>	<input type="checkbox"/>
20	Inflammation of the bowel including Crohns Disease, Ulcerative Colitis, bleeding from the rectum or diarrhoea lasting more than one week?	<input type="checkbox"/>	<input type="checkbox"/>
21	Irritable bowel syndrome?	<input type="checkbox"/>	<input type="checkbox"/>
22	Jaundice or any form of Hepatitis or other liver problem?	<input type="checkbox"/>	<input type="checkbox"/>
23	Any other abdominal complaint including a hernia?	<input type="checkbox"/>	<input type="checkbox"/>

Back, joint and related conditions

	Have you had any past or current history of the following?	Yes	No
24	Problems with back pain (including neck pain) or sciatica?	<input type="checkbox"/>	<input type="checkbox"/>
25	Any knee pain, foot pain, injury or dislocation to any joint?	<input type="checkbox"/>	<input type="checkbox"/>
26	Any broken bones or fractures?	<input type="checkbox"/>	<input type="checkbox"/>
27	Any other cause of muscle or joint pain e.g. rheumatism, fibromyalgia?	<input type="checkbox"/>	<input type="checkbox"/>
28	Have you ever consulted an Orthopaedic Surgeon, Physiotherapist, Chiropractor or Osteopath?	<input type="checkbox"/>	<input type="checkbox"/>
29	Have you been diagnosed as having any form of arthritis, gout, or chondromalacia patellae?	<input type="checkbox"/>	<input type="checkbox"/>

Mental Health and related conditions

	Have you had any past or current history of the following?	Yes	No
30	Anxiety or depression, phobias, mental breakdown or stress related problems?	<input type="checkbox"/>	<input type="checkbox"/>
31	Any eating disorder such as anorexia or bulimia nervosa?	<input type="checkbox"/>	<input type="checkbox"/>
32	Any other mental illness?	<input type="checkbox"/>	<input type="checkbox"/>
33	Substance abuse for example of drugs, steroids or alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
34	Any history of self-harm or attempted suicide?	<input type="checkbox"/>	<input type="checkbox"/>

Kidney, bladder and related conditions

	Have you had any past or current history of the following?	Yes	No
35	Kidney Stones?	<input type="checkbox"/>	<input type="checkbox"/>
36	Recurrent kidney or urinary infections like cystitis or urethritis?	<input type="checkbox"/>	<input type="checkbox"/>
37	Blood in your urine?	<input type="checkbox"/>	<input type="checkbox"/>
38	Any other kidney or bladder diseases?	<input type="checkbox"/>	<input type="checkbox"/>
39	Any disorders of the reproductive organs including gynaecological, breast or testicular problems?	<input type="checkbox"/>	<input type="checkbox"/>

Respiratory

	Have you had any past or current history of the following?	Yes	No
40	Asthma?	<input type="checkbox"/>	<input type="checkbox"/>
41	Bronchitis, emphysema, pleurisy, pneumonia or any other lung diseases including TB or a pneumothorax?	<input type="checkbox"/>	<input type="checkbox"/>

General

	Have you had any past or current history of the following?	Yes	No
42	Any blood disorder such as anaemia, thalassaemia or bleeding disorder?	<input type="checkbox"/>	<input type="checkbox"/>
43	Any skin disorders such as Psoriasis, Eczema, allergic skin rash or other skin disease?	<input type="checkbox"/>	<input type="checkbox"/>
44	Any infectious diseases (apart from childhood illnesses) including sexually transmitted (e.g. HIV) or tropical diseases?	<input type="checkbox"/>	<input type="checkbox"/>
45	Any general allergies e.g. hayfever, nut allergy or anaphylaxis?	<input type="checkbox"/>	<input type="checkbox"/>
46	Any other operations or surgical procedures not previously mentioned?	<input type="checkbox"/>	<input type="checkbox"/>
47	Any malignancies or cancers?	<input type="checkbox"/>	<input type="checkbox"/>
48	Any unexplained weight loss in past year?	<input type="checkbox"/>	<input type="checkbox"/>
49	Any currently prescribed medication including tablets, capsules, injections and inhalers (excluding birth control)? Please list in comments section	<input type="checkbox"/>	<input type="checkbox"/>
50	Are you currently attending a hospital or your GP for treatment or waiting for an appointment, treatment or operation?	<input type="checkbox"/>	<input type="checkbox"/>

COMMENTS BOX

If you have answered YES to any of the questions numbered 1-50 above, please insert the relevant question number and answer each of the questions A-H, when completing the Comments Box below:

- A) What was the condition?
- B) When did you have it?
- C) How often did you have it?
- D) How long did you have it?
- E) Who treated the condition?
- F) What was the treatment?
- G) Do you still require treatment? (if yes, please give details)
- H) Please provide further information on this condition to support the OHW Medical Decision on your fitness to be a Police Constable. (Examples of further information include: scan results, letters/reports from health professionals, medical investigations.) Have you included further information? If not, why?

Medical Condition Question Number	Comments Please answer A-H above when completing this section

Sickness Absence

Please list how many days you have been absent from work, school or college etc., in the last three years due to sickness. For each period of absence please also indicate the dates and the reason:

Number of days absence	Dates of absence (dd/mm/yyyy)	Reason for absence

Miscellaneous

		Yes	No
51	Have you ever failed a medical examination (or had special conditions imposed) for any employment reason (including Police Services and HM Forces) or life assurance?	<input type="checkbox"/>	<input type="checkbox"/>
52	Have you previously been notified that you would not be eligible for ill health benefits if appointed to the Police Service?	<input type="checkbox"/>	<input type="checkbox"/>
53	Have you ever left a job or had to be medically retired due to ill health?	<input type="checkbox"/>	<input type="checkbox"/>
54	Has any previous occupation caused you health problems?	<input type="checkbox"/>	<input type="checkbox"/>
55	Are you in receipt of a medical pension or other disability benefit?	<input type="checkbox"/>	<input type="checkbox"/>

COMMENTS BOX

If you have answered YES to any of the questions numbered 51-55 above, please insert the question number and complete the Comments Box below:

Question number	Comments

SECTION B

This short set of questions asks you how you manage with practical activities. This can include activities at home, in work, at school or college, or even related to pastimes, such as sporting activities.

It may be that you have no problem undertaking any activities at any time. Alternatively, you may have difficulty sometimes or even quite often. Please answer all the questions below and then complete the Comments Box if any difficulty.

	Do you have difficulty with any of the following:-	Yes	No
56	Mobility E.g., sitting (including in a car), walking, standing, using stairs, running.	<input type="checkbox"/>	<input type="checkbox"/>
57	Manual dexterity E.g., using your hands or fingers.	<input type="checkbox"/>	<input type="checkbox"/>
58	Ability to lift, carry, kneel, stoop, bend, pull, push or otherwise move objects E.g., this could be anything from 'light' to 'heavy' objects	<input type="checkbox"/>	<input type="checkbox"/>
59	Physical co-ordination E.g., placing items or objects correctly without dropping them or maintaining your balance.	<input type="checkbox"/>	<input type="checkbox"/>
60	Continence E.g., incontinence of bowels or urine, or a sense of urgency that could result in incontinence.	<input type="checkbox"/>	<input type="checkbox"/>
61	Speech, hearing and eyesight E.g., difficulties with conversation, hearing or giving instructions, problems seeing clearly even with glasses or contact lenses.	<input type="checkbox"/>	<input type="checkbox"/>
62	Memory or ability to concentrate, learn or understand E.g., problems following instructions or concentration, being forgetful, problems remembering, learning or coping with changes in daily routine, difficulty in conversations and communications with others.	<input type="checkbox"/>	<input type="checkbox"/>
63	Perception of risk of physical dangers E.g., experience of loss of consciousness and associated confused behaviour, unaware of common indoor dangers (e.g. fires, gas taps, power points).	<input type="checkbox"/>	<input type="checkbox"/>

COMMENTS BOX	
<p>If you answered YES to any of the above questions numbered 56-63 please provide further information below giving examples of how you are affected and what you do to cope with any difficulties you might have:</p>	
Question Number	Comments

Disability Discrimination Act 1995 (DDA)

The DDA defines a disability as “a physical or mental impairment which has a substantial (more than minor or trivial) and long term (has lasted or is or likely to last 12months or more) adverse effect on his or her ability to carry out normal day to day activities”

Do you consider yourself to have a disability as defined above?	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>

If yes, are there any adjustments/changes that might help you perform the role of a Police Constable – Patrol /Probationer?	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>

If YES, please list the medical condition and the adverse effect:

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Further Details

Please tick the appropriate box if you have enclosed additional information relating to any medical condition	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is there any other matter concerning your health not covered by the previous questions, which the Occupational Health Nurse or Doctor should know about?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If you have answered YES to this question, please provide further details in the Comments Box below:		

COMMENTS BOX:

Declaration

The information I have provided in this form is accurate and I have not withheld any relevant details. I understand that the giving of false information or withholding any relevant information could result in rejection from the recruitment process or dismissal at a later stage if employment is offered.

Signed: _____ Date: _____

Final Instructions

- At this stage you must now bring this completed form to your GP. **YOUR SIGNATURE/DATE OF COMPLETION MUST CLEARLY PRE DATE THAT OF YOUR GENERAL PRACTITIONER.** Failure to do so will lead to a delay in your assessment.
- Please ask your GP to read the information detailed in the letter on the next page and to complete their section of the form on pages 12 and 13. The GP must then sign, date and stamp the form on Page 13 with their Practice stamp.

Finally, please complete the checklist on Page 14 and then bring the entire document to your medical examination.

SECTION C

For the attention of the General Practitioner

Your patient has applied for selection for the job role of a Police Constable – Patrol/Probationer. Accurate completion of this form is an essential part of the recruitment process. **It will not be necessary for you to undertake a Medical Examination of the candidate for this process**

Please note:

For job roles such as Police Constable – Probationer/Response, his/her health status will be assessed against the NATIONAL MEDICAL STANDARD as required by the Police Service of Northern Ireland (PSNI). All Job Profiles will be made available by the candidate.

To ensure all relevant medical evidence has been considered your patient is requested to provide “Additional Medical Information” as part of their health assessment. This is of particular relevance if a **YES** answer is ticked in the medical questionnaire.

“Additional Medical Information” includes letters or reports relating to a medical condition requiring current or past treatment and/or attendance with the following:

- A General Practitioner;
- Other medical specialists e.g. hospital based doctors or relevant specialists;
- Other paramedical specialists e.g. Physiotherapist, Chiropractor, Osteopath; and
- *Any other relevant treating practitioner.*

Your patient has been instructed to include ALL information with their Medical History Questionnaire. Please refer to Questions answered by the candidate in Section A and B and provide any additional information as appropriate. The Occupational Health Nurse or Doctor will not be in a position to request a specific report on a candidate’s behalf.

All medical information remains entirely confidential to the **Occupational Health Multi-disciplinary team** and will become part of the candidate’s Occupational Health record if selected into the Police Service of Northern Ireland.

The candidate will pay for any fee required for the completion of this form.

Thank you for your co-operation and assistance to the candidate.

Please read the information on the previous page before answering the following questions:

		Yes	No
64	Is there any medical reason why the patient should not undertake strenuous physical exercise or undertake a maximal fitness assessment?	<input type="checkbox"/>	<input type="checkbox"/>
65	Are you in possession of the patient's complete medical history?	<input type="checkbox"/>	<input type="checkbox"/>
66	If the answer to question 65 is 'NO', what years do the records cover? Years From: To:		
67	If you have records, according to these and your knowledge of the patient, do the answers given by him/her in the questionnaire appear correct?	<input type="checkbox"/>	<input type="checkbox"/>
68	Is there anything in the GP records that may indicate a risk of having access to a firearm (for example emotional volatility, mental health disorders, anger control or self-harm) or which you think should be considered by the medical officer in this regard? If so, please comment below	<input type="checkbox"/>	<input type="checkbox"/>
69	Are you aware of any other medical information, which might be relevant to this application? (You may provide further clarification in the Comments Box below).	<input type="checkbox"/>	<input type="checkbox"/>

COMMENTS BOX	
<p>Please use this section to provide further clarification on any of the answers to questions numbered 1 – 69 as appropriate.</p> <p>Please attach additional pages if required.</p>	
Question Number	Comments

Current Vaccination status if known (a printout is also acceptable)

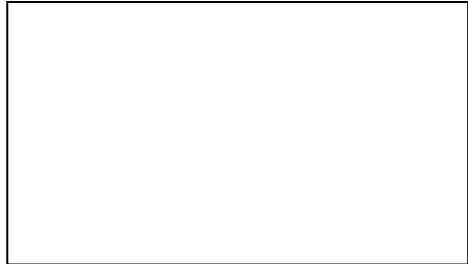
		Date of Vaccination	Course Completed
70	Polio		
71	Tetanus		
72	BCG		
73	Hep A		
74	Hep B*		

* NB: A course of vaccinations against Hepatitis B will be undertaken if the candidate is appointed as Police Constable – Patrol/Probationer unless the candidate has been previously vaccinated.

General Practitioner's Report

Please remember that failure to sign, date and stamp the above section will result in non-acceptance of the candidate's application

Practice Stamp:



GP Signature _____

Date _____

Thank you for completing this document.

Candidate's Final Checklist

Before you return this form please ensure:

	YES
You have completed your candidate details on page 3 including your UID number?	<input type="checkbox"/>
You have completed all questions in sections A and B, and signed and dated appropriately.	<input type="checkbox"/>
Where you have ticked YES to a question you have provided detail in the Comments Box under each section.	<input type="checkbox"/>
You have attached additional medical documentation as appropriate and have ensured that your UID number is clearly marked on each additional page.	<input type="checkbox"/>
Your General Practitioner has completed SECTION C.	<input type="checkbox"/>
Your General Practitioner has signed, dated and stamped SECTION C.	<input type="checkbox"/>

Notes: