

## ST NICHOLAS HOSPITAL, SALISBURY

### Medical Questionnaire

Before you are interviewed, we would be grateful if you would answer the following questions. The Trustees may with your permission request further information from your GP.

Answering **YES** to any of the questions under section 2 will not necessarily prevent you from joining the Community, but it is important that we are aware of any physical illness, mental health needs or disabilities so that we are best positioned to support you, were you to be accepted as a member of the Community of St Nicholas.

1. Are you currently in good health? YES/NO

2. Have you ever suffered from or are currently suffering from:

- Difficulties with vision which are not fully corrected by spectacles or contact lenses. YES/NO
- Difficulties with hearing YES/NO
- Fits, epilepsy, fainting, blackouts, giddiness or loss of consciousness YES/NO
- Mental health difficulties YES/NO
- Angina/heart attack/ other heart conditions YES/NO
- Diabetes YES/NO
- Rheumatism or arthritis YES/NO
- Difficulties with lifting and/or bending YES/NO
- Difficulties with walking or using stairs YES/NO
- Any other health concerns YES/NO

If yes, please give details below

3. Do you take regular prescribed medication? YES/NO

If Yes, please give details below:

4. Please give details of any significant illnesses, injuries or operations during the last five years

5. Are there any other health or social factors that you would wish the trustees to take into consideration when assessing your application? YES/NO

If Yes, please give details below:

**Authority To Request Medical Data**

I hereby give my agreement to give details of my medical history to:

The Hospital of St Nicholas Salisbury  
St Nicholas Road  
SALIEBURY  
Wiltshire SP1 2SF

Name in full:

Date of Birth:

Address including postcode:

NHS number if known:

Name, Address and contact details of your GP:

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Telephone Number of GP: \_\_\_\_\_

E mail address (if known): \_\_\_\_\_

**Declaration and signature.**

I declare that the information I have given is complete and accurate. I give permission for this information to be shared with the Trustees of St Nicholas Hospital if appropriate.

Name: .....

Signature: ..... Date: .....