



Confidential Medical History Form

Completion of this form will enable the Isle of Man Fire and Rescue Service's Medical Adviser to make a general assessment as to whether you comply with the medical standards required for the post. A 'Yes' answer does not mean you will be automatically rejected. You may be contacted if further details are required.

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.

If the answer to any question in Part A is yes then you will be required to submit Part B completed by your GP prior to being allowed to participate in any assessment. Part B completion will also be required prior to any job offer.

Family Name: _____ Forename: _____

Date of Birth: _____ Male/Female: _____

Address: _____

General Practitioners

Name: _____ Address: _____

Telephone No: _____

PART A

Medical Condition	YES	NO	Details
If you have ever had any of these conditions answer all the questions opposite indicating the question number. This will assist the medical adviser in clarifying the significance or otherwise of a 'yes' answer.			When did you have it? How often did you have it? How long did you have it? Who treated the condition? What was the treatment? Do you still require treatment? How long were you off school or work?
1. Epilepsy, fits, blackouts, fainting turns or unexplained loss of consciousness.			

Medical Condition	YES	NO	Details
2. Head Injuries leading to loss of consciousness requiring hospital admission.			
3. Recurrent headache or migraine.			
4. Diseases of the nervous system e.g. neuritis, stroke, multiple sclerosis.			
5. Eye disease, injury or surgery.			
6. Any visual defect including temporary visual problems.			
7. Ear infection, discharge, tinnitus, a hearing defect including deafness.			
8. Vertigo, dizziness, giddiness, problems with balance.			
9. Chest pain, angina or heart disease.			
10. Varicose veins or circulation problems.			
11. Rheumatic fever.			
12. Raised blood pressure.			
13. Any blood disorder.			
14. Asthma, bronchitis, emphysema, pleurisy, pneumonia or any other lung disease including TB.			
15. Recurrent nausea, dyspepsia, heartburn, indigestion or hiatus hernia.			
16. Gastric, duodenal or peptic ulcer.			

Medical Condition	YES	NO	Details
17. Inflammation of the bowel including Crohn's Disease, Ulcerative Colitis, bleeding from rectum or diarrhoea lasting more than a week.			
18. Irritable bowel syndrome.			
19. Jaundice or any form of Hepatitis or other liver problem.			
20. Any other abdominal complaint including hernia.			
21. Kidney stones.			
22. Recurrent kidney infection. Blood in urine.			
23. Any other kidney disease. Any problems with any bones or joints including back, neck, sciatica or major fracture.			
24. Have you ever consulted an Orthopaedic Surgeon, Chiropractor or Osteopath.			
25. Have you been diagnosed as having Arthritis, Gout, Chondromalacia.			
26. Psoriasis, eczema, allergic skin rash or other skin disease.			
27. Any metabolic disorder including diabetes, thyroid and adrenal gland disease.			
28. Any disorders of reproductive organs including gynaecological, testicular and breast problems.			
29. Any infectious diseases (apart from childhood illnesses) including sexually transmitted disease.			

Medical Condition	YES	NO	Details
30. Anxiety/depression, phobias, mental breakdown or stress related problems.			
31. Any other mental illness.			
32. Substance abuse (ie drugs, steroids, alcohol).			
33. Any allergies including hayfever.			
34. Any surgical procedure.			
35. Any malignancies or cancers.			
36. Any unexplained weight loss in past year.			
37. Have you attended hospital in the last year.			
38. Are you currently waiting for a hospital appointment or treatment, eg surgery.			
39. Time off work or school or necessitating retirement.			
40. Current prescribed medication including tablets, capsules, injections and inhalers.			

- Is there any other matter concerning your health not covered by the above questions which we should know about and may impact on your suitability to attend the fitness assessment?

YES/NO

Details:

If the answer to any question in Part A is yes then you will be required to submit Part B completed by your GP prior to being allowed to participate in any assessment. Part B completion will also be required prior to any job offer.

The information I have provided is accurate and I have not withheld any relevant details. I understand that the giving of false information or withholding relevant information could result in dismissal.

Signed:_____

Date:_____

If it is required, I hereby authorise my general practitioner to release details of my medical history to the nominated Isle of Man and Rescue Service's Medical Officer.

- I wish/ do not wish to see the report prior to submission.

Signed:_____

Date:_____

PART B
General Practitioners Comments

1. From the medical records available is there any medical reason why your patient should not undertake the Isle of Man Fire and Rescue Service's fitness test and associated physical exercise; including shuttle running, ladder climbing and crawling through confined spaces whilst wearing a breathing apparatus set on their back?
This list is not exhaustive.

YES/NO

2. Are you in possession of this patient's complete medical history?

YES/NO

3. According to these records and your knowledge of the application, do the answers given by him/her in the questionnaire appear correct?

YES/NO

4. Are you aware of any other medical information, which might be relevant to this application?

Please note: A Medical Examination is not required.

Date: _____ Signed: _____

Practice Stamp

Please note: Any fee required for the completion of this form will be paid by the applicant. This should be the current fee as agreed between the British Medical Association and the Local Government Management Board (DC Circular No 27.)