MEDICAL CONFIDENTIAL

Health Surveillance Questionnaire (Initial) for Persons who will be working with Known Respiratory Sensitizers and/or Skin Sensitizers

To be completed by the Company

COMPANY:	JMS SPECIALIST JOINERY LTD
JOB TITLE:	JOINER
EMPLOYEE'S SURNAME:	DRINKWATER
EMPLOYEE'S FORENAMES:	PAUL

Substances are in use in this workplace which have been known to cause:

- allergic chest problems.
- skin disease or adverse effects on the skin.

Following risk assessment under Regulation 6 of the Control of Substances Hazardous to Health Regulations (COSHH), management have decided to carry out a programme of pre-exposure and periodic health surveillance in accordance with Regulation 11(2) (b) of COSHH.

In some cases, further advice may be required from the company occupational health adviser.

I understand that a programme of health surveillance is necessary in this employment and will form part of my management health record.

Signature of Employee: ..... Date: 09/09/23

Signature of Responsible Person: ..... Date: .....

Referred for further investigation? ☐Yes ☐No

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To be completed by the Employee

To be Completed by the Employee

Please read the questions carefully and write your answers in ink, as accurately and fully as possible. This questionnaire and its contents are absolutely confidential.

SURNAME:	DRINKWATER
FORENAMES:	PAUL
Date of Birth:	26/05/87 Age: 36
National Insurance Number:	JR91 95 91 D

Home Address:	315 TACHBROOK ROAD LEAMINGTON SPA WARWICKSHIRE Postcode: CV31 3DE Telephone No:		
Next of Kin:	NIAMH DRINKWATER	Relationship:	WIFE
Next of Kin Address:	315 TACHBROOK ROAD LEAMINGTON SPA WARWICKSHIRE Postcode: CV31 3DE Telephone No:		
Name of Family Doctor (GP):			
GP Address:	Postcode: Telephone No:		

Please read the questions carefully and write your answers in ink, as accurately and fully as possible. This questionnaire and its contents are absolutely confidential.

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Part 1 - INITIAL HEALTH SURVEILLANCE QUESTIONNAIRE (Respiratory)

SURNAME: Drinkwater

FORENAMES: Paul

	No	Yes
Do you believe that your chest has suffered as a result of any previous employment?	✓	

Do you have, or have you ever had any of the following? (Do not include isolated colds, sore throats or flu)	No	Yes
1.1 Recurring soreness of or water of eyes	✓	
1.2 Recurring blocked or running nose	✓	
1.3 Bouts of coughing	✓	
1.4 Chest tightness	✓	
1.5 Wheezing	✓	
1.6 Breathlessness	✓	
1.7 Any other persistent chest problems	✓	

Part 2 - INITIAL HEALTH SURVEILLANCE QUESTIONNAIRE (Skin)

	No	Yes
Do you believe that your skin has been damaged as a result of any previous employment?	✓	

Do you have, or have you ever had any of the following skin conditions?	No	Yes
Itching.		✓
Pain.	✓	
Redness.		✓
Soreness.	✓	
Swelling.	✓	
Blistering.	✓	
Cracked skin		✓
Bleeding for no apparent reason.	✓	

Has your past employment included contact with the following? Where the answer is YES, please give full details below, indicating the question number:	No	Yes
Chemical irritants - such as caustic soda, fresh mixed cement, acids, metals such as nickel or chromium, solvents, hydrocarbons.	✓	
Chemical sensitizers - such as dyes and dye intermediates, photographic developers, rubber accelerators and antioxidants, insecticides, oils, resins, coal tar derivatives, explosives, plasticizers, rubber or leather gloves.	✓	
Plants and their products - such as cinnamon, henna, primrose.	✓	
Biological agents - such as grain, copra, scabies.	✓	
Mechanical causes - such as cuts or abrasions followed by secondary infections, repeated trauma between tools and skin pressure points.	✓	
Physical factors - such as heat causing skin softening, cold causing chilblain/frostbite, burns from fire, electricity, sun, ionizing radiation.	✓	

Part 3 - INITIAL HEALTH SURVEILLANCE QUESTIONNAIRE (Vibration)

SURNAME:	DRINKWATER
FORENAMES:	PAUL

	No	Yes
Have you ever used hand-held vibrating tools, machines or hand-fed processes in your job?		✓
If YES: (a) state year of first exposure (b) when was the last time you used them?		2003 – DATE

		No	Yes
1.	Do you have any tingling of the fingers lasting more than 20 minutes after using vibrating equipment?	✓	
2.	Do you have tingling of the fingers at any other time?	✓	
3.	Do you wake at night with pain, tingling, or numbness in your hand or wrist?	✓	
4.	Do one or more of your fingers go numb more than 20 minutes after using vibrating equipment?	✓	
5.	Have your fingers gone white* on cold exposure?	✓	
6.	If Yes to 5, do you have difficulty rewarming them when leaving the cold?	✓	
7.	Do your fingers go white at any other time?	✓	
8.	Are you experiencing any other problems with the muscles or joints of the hands or arms?		✓
9.	Do you have difficulty picking up very small objects, e.g. screws or buttons or opening tight jars?	✓	
10.	Have you ever had a neck, arm or hand injury or operation? If so give details		✓
11.	Have you ever had any serious diseases of joints, skin, nerves, heart or blood vessels? If so give details:	✓	
12.	Are you on any long-term medication? If so give details:	T.B.C.	

WAITING ON HOSPITAL TO SORT MEDS FOR MY STOMACH.

Part 4 - ON-GOING HEALTH SURVEILLANCE QUESTIONNAIRE (Noise)

SURNAME: DRINKWATER

FORENAMES: PAUL

Questions	YES	NO	Details
Do you wear a hearing aid?		✓	
Do you have any trouble with your hearing?	✓		
Have you ever attended your doctor with ear problems or hearing difficulties?		✓	
Have you ever had a serious head injury?		✓	
Do you suffer with vertigo or dizziness?		✓	
Is there any deafness in your family?			
Do you suffer from noises or ringing in the ears?	✓		
Have you had a recent cold or nasal congestion?		✓	
Are you on any medication?	✓		FOR MY STOMACH
Have you had measles / mumps/meningitis/scarlet fever?		✓	
Have you had regular exposure to gunfire or explosions?		✓	
Are you exposed to any activities/hobbies out of work that involve loud noises?		✓	
Have you had a previous hearing test?	✓		
If you have had a previous hearing test, have any issues been identified?		✓	
Do you work in an area designated for the use of hearing protection?	✓		
Have you been issued with hearing protection?	✓		
Have you been instructed in the use of and maintenance of your hearing protection?	✓		
What type of hearing protection have you been issued with?			EAR DEFENDERS
Do you use the hearing protection in designated hearing protection areas?	✓		
Do you suffer from noises or ringing in the ears?		✓	
Have you been working in a noisy environment in the last 48 hours?		✓	

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No further action required ☐

Further action required ☐

Refer to company occupational health adviser ☐

Further Action Required:

I confirm that the responses given by me are correct and that I have received a copy of the completed questionnaire.

Signature of responsible person:

Date:

To be completed by the employee

Signature of employee:

Date: