



**RAPHAEL**  
CONTRACTING LTD



**SPECIALIST**  
JOINERY LIMITED

**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 Joinery

JOB TITLE: Bench joiner

EMPLOYEE'S SURNAME: Jones

EMPLOYEE'S FORENAMES: Mason

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: 12/12/21

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

Referred for further investigation?

☐ Yes

☐ No



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**To be completed by the Employee**

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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: Jones

FORENAMES: Mason

Date of Birth: 20/07/2005 Age: 16

National Insurance Number: PK 70 73 37 A

Home Address: 1st James crescent	Postcode: CV47 0LX Telephone No: 07500 588038		
Next of Kin: Brett Jones		Relationship: Father	
Next of Kin Address: 1st James crescent	Postcode: CV47 0LX Telephone No: 07711 871799		
Name of Family Doctor (GP): Dr O'Brien			
GP Address: Stoke drive Southern Surgery Southern	Postcode: CV47 1NY Telephone No: <del>07500 588038</del>		

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: *Jones*

FORENAMES: *Mason*

	No	Yes
Do you believe that your chest has suffered as a result of any previous employment?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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	<input checked="" type="checkbox"/>	<input type="checkbox"/>
1.2 Recurring blocked or running nose	<input checked="" type="checkbox"/>	<input type="checkbox"/>
1.3 Bouts of coughing	<input checked="" type="checkbox"/>	<input type="checkbox"/>
1.4 Chest tightness	<input checked="" type="checkbox"/>	<input type="checkbox"/>
1.5 Wheezing	<input checked="" type="checkbox"/>	<input type="checkbox"/>
1.6 Breathlessness	<input checked="" type="checkbox"/>	<input type="checkbox"/>
1.7 Any other persistent chest problems	<input checked="" type="checkbox"/>	<input type="checkbox"/>

**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?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Do you have, or have you ever had any of the following skin conditions?	No	Yes
Itching.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Pain.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Redness.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Soreness.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Swelling.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Blistering.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Cracked skin	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Bleeding for no apparent reason.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Plants and their products - such as cinnamon, henna, primrose.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Biological agents - such as grain, copra, scabies.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Mechanical causes - such as cuts or abrasions followed by secondary infections, repeated trauma between tools and skin pressure points.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Physical factors - such as heat causing skin softening, cold causing chilblain/frostbite, burns from fire, electricity, sun, ionizing radiation.	<input checked="" type="checkbox"/>	<input type="checkbox"/>





**Part 3 - INITIAL HEALTH SURVEILLANCE QUESTIONNAIRE (Vibration)**

SURNAME: Jones

FORENAMES: Mason

	No	Yes
Have you ever used hand-held vibrating tools, machines or hand-fed processes in your job?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
If YES:	<input checked="" type="checkbox"/>	<input type="checkbox"/>
(a) state year of first exposure		
(b) when was the last time you used them?		

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



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

SURNAME: *James*

FORENAMES: *Matthew*

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



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**To be completed by the company**

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:**

*[Handwritten signature]*

**Date:** 12/12/21