Skin Surveillance Questionnaire

Name	
Date of Birth	
Employer	**HIGHLAND COUNCIL**
Worksite	
Job Title	

Duration in post	
Which areas do you work in?	

	Which chemicals or substances do you work with and how often?	YES	DAILY	WEEKLY	OCCASIONALLY	NEVER
1	Paints & thinners	☐	☐	☐	☐	☐
	Lube oils & greases	☐	☐	☐	☐	☐
	Adhesives & glues	☐	☐	☐	☐	☐
	Grinding abrasives	☐	☐	☐	☐	☐
	Dust & particles	☐	☐	☐	☐	☐
	Biocides	☐	☐	☐	☐	☐
	Condensates	☐	☐	☐	☐	☐
	Laboratory chemicals	☐	☐	☐	☐	☐
	Food	☐	☐	☐	☐	☐
	General cleaning materials	☐	☐	☐	☐	☐
	Amines	☐	☐	☐	☐	☐
	Epoxy resins	☐	☐	☐	☐	☐
2	**Protective Equipment**	**ALWAYS**	**RARELY**	**OCCASIONALLY**		**NEVER**
	Do you use protective gloves?	☐	☐	☐		☐
	Are these gloves PVC?	☐	☐	☐		☐
	Are these gloves leather?	☐	☐	☐		☐
	Do you use barrier creams?	☐	☐	☐	☐	☐ ☐
	Do you use an aftercare cream?	☐	☐	☐		☐
3	Did you have any history of skin disease prior to starting this job?				YES ☐	NO ☐
	If **yes**, please give details:					
	Do you suffer from hay fever or asthma?				YES	NO
4	**Have you ever suffered from any of the following since starting?**	**YES**	**NO**	**Please give details**		
	Eczema	☐	☐			
	Dermatitis	☐	☐			
	Itchy skin	☐	☐			
	Redness/ swelling / dry / flaky skin	☐	☐			

	Allergic skin or respiratory reactions	☐	☐	
	Any other skin rashes / blisters / spots	☐	☐	

Name		Date of Birth	

5	Do you think that your job has caused or worsened any skin condition you have had?	YES	NO
6	Have you had any treatment for a skin condition since starting your current job?	YES ☐	NO ☐
	If **yes**, please give details:		
7	Have you ever seen a doctor (GP Consultant, Occupational Physician) about a skin problem since starting your current post?	YES ☐	NO ☐

Declaration

I declare that the information provided on this form is true to the best of my knowledge and belief. I understand that the information remains confidential and will only be used by the occupational health professionals.

I consent to the outcome of the health surveillance being passed to my employer.

Signature: _____ Date: _____

Clinical Assessment – To be completed by clinical staff

Assessment

_____

_____

_____

Recommendation

_____

_____

_____

_____

Result

☐ Fit

☐ Further Assessment Required

Reason for Referral to Medical Advisor (for medical Advisor Referral Information)

_____

_____

_____

OHN Signature: _____ Date: _____

OHN Name: _____