Combined Skin & Respiratory Surveillance Questionnaire

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

History of Occupational Exposure in Previous Employment

	Have you ever had exposure to	YES	NO	Please give details
1	Chemicals	☐	☐	
	Oils & greases	☐	☐	
	Dust & particles	☐	☐	
	Welding / smelting	☐	☐	
	Lead / chrome / mercury	☐	☐	

2	Do you believe your health has been affected as a result of exposure to occupational hazards in any previous employment?	YES ☐	NO ☐
	If **yes**, please describe what symptoms you have experienced:		

Current Occupational Exposure

	Do you currently have exposure to	YES	DAILY	WEEKLY	OCCASIONALLY	NEVER
3	Paints & thinners	☐	☐	☐	☐	☐
	Lube oils & greases	☐	☐	☐	☐	☐
	Adhesives & glues	☐	☐	☐	☐	☐
	Grinding abrasives	☐	☐	☐	☐	☐
	Dust & particles	☐	☐	☐	☐	☐
	Biocides	☐	☐	☐	☐	☐
	Condensates	☐	☐	☐	☐	☐
	Laboratory chemicals	☐	☐	☐	☐	☐
	Food	☐	☐	☐	☐	☐
	General cleaning materials	☐	☐	☐	☐	☐
	Amines	☐	☐	☐	☐	☐
	Epoxy resins	☐	☐	☐	☐	☐

4	Do you think your current job has caused or worsened any health condition?	YES ☐	NO ☐
	If **yes**, please describe what symptoms you have experienced:		

Smoking History

	Are you a Smoker?	YES ☐	NO ☐
	Have you smoked in the past?	YES ☐	NO ☐

5	If so, when did you stop?	
	How many cigarettes / cigars do you smoke per day?	

Name		Date of Birth	

Medical History

Have you ever suffered from any of the following conditions, not including common cold, sore throats or flu?

	Condition	YES	NO	Please give details
6	Injury or operation affecting your chest	☐	☐	
	TB (tuberculosis)	☐	☐	
	Pleurisy	☐	☐	
	Recurring soreness or watering of eyes	☐	☐	
	Recurring blocked or running nose	☐	☐	
	Persistent cough	☐	☐	
	Chest tightness	☐	☐	
	Wheezing	☐	☐	
	Breathlessness	☐	☐	
	Hay fever	☐	☐	
	Asthma	☐	☐	
	Eczema	☐	☐	
	Dermatitis	☐	☐	
	Itchy skin	☐	☐	
	Redness/ swelling / dry / flaky skin	☐	☐	
	Allergic skin or respiratory reactions	☐	☐	
	Any other skin rashes / blisters / spots	☐	☐	

7	During the past 3 years, have you had any chest or skin condition which has prevented you from completing your usual activities for as long as a week?	YES ☐	NO ☐
	If **Yes**, how many episodes of symptoms have you experienced in the last 3 years?		
	Please describe what symptoms you have experienced:		
8	Did you have any history of skin or respiratory conditions prior to starting your current job?	YES ☐	NO ☐
9	Have you had any treatment for a skin or respiratory condition since starting your current job?	YES ☐	NO ☐
10	Have you seen a doctor (GP, Consultant, Occupational Health Physician) regarding a skin or respiratory condition since starting your current job?	YES ☐	NO ☐
	If **yes** to either of the last two questions, please detail your treatment:		

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: _____

Name		Date of Birth	

Clinical Assessment – To be completed by clinical staff

Clinician please note it is not necessary to duplicate any information documented elsewhere in today's medical but **please fill in the result section.**

Height		Age		BP	
Spirometry ID Number					

Spirometry Results	Test 1	Test 2	Test 3	Predicted	% Predicted
FEV1					
FVC					
FEV1/FVC Ratio (percentage)					
PEF					
Summary:	**Normal** ☐		**Obstructive** ☐		**Restrictive** ☐

Skin and Respiratory Examination

_____

_____

_____

Result

☐ Fit

☐ Further Assessment Required

Comments Regarding Further Assessment (to enable appropriate referral)

_____

_____

_____

Clinician Signature:_____ Date: _____

Clinician Name: _____ Designation: Nurse / Physician