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| OccupationalHealth_mono |  **C O N F I D E N T I A L** |

**INITIAL**

HEALTH SURVEILLANCE FORM

For those working with Respiratory Sensitisers

#

Exposure to laboratory animals / chemicals /birds /insects/ glutaraldehyde / solvents / spores / flour / isocyanates can cause allergic reactions and lung disease. Legislation requires that all staff working in these environments participate in health surveillance at regular intervals following a full risk assessment carried out by their line manager.

Health surveillance will take place as follows:-

* Pre-employment
* 6 weeks after employment
* 6 months after employment
* One year from date of employment
* Annually thereafter

The annual checks will consist of a questionnaire, however, if there are concerns regarding any of the answers in this questionnaire, individuals will be invited to attend the Occupational Health Unit for further assessment/investigation.

The annual questionnaire and return envelopes will be distributed by the Unit/Line Manager. The questionnaire should be completed and sealed into the accompanying envelope confidentially and returned to the Unit/Line Manager. All questionnaires require to be completed and every question should be answered. If this is not the case, questionnaires will be returned to the individual for full completion.

All information you provide is confidential to the Occupational Health Unit and is kept as part of your medical records.

|  |  |
| --- | --- |
| **Surname:** | **Title:** |
| **First name(s)** | **M\F:** |
| **National Insurance No.** | **DOB:**  |
| **Date started work** |  |
| **Work address:** |  |
|  |  |
| **Your Contact Details:** | **Email:** **Phone:**  |
| **Job Title:** |  |
| **Line Manager:**  |  |
| **Admin/HealthSurveillance****Contact Person:** |  |

**Occupational Health Information**

**Please answer the questions which apply to your work, placing a tick in the appropriate column,**

**unless otherwise indicated.**

**PRESENT EMPLOYMENT**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Yes** |  |  **No** |
| **Working with animals/insects/birds?** |  |  |  |  |
|  |  |  |  |  |
| **If Yes what type of birds, insects or animals do you work with?** |
|  |
|  |
|  |  |  |
| **How long have you worked with them?** |  |  |
|  |  |  |  |  |
| **Do you handle them?** |  |  |  |  |
|  |  |  |  |  |
| **If yes, how many hours per day, approximately?** |  |  |
|  |  |  |  |  |
| **If you do not handle birds, insects or animals do you work within an area where they are routinely handled?** |  |  |  |  |
|  |  |  |  |  |
| **If yes, how many hours per day, approximately, are you****In the environment?** |  |  |
|  |  |  |  |  |
| **Do you wear any Personal Protective Equipment?** |  |  |  |  |
|  |  |  |  |  |
| **If so what type?** |  |  |
|  |  |  |  |  |

**PAST EMPLOYMENT**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **What other birds, insects or animals have you worked with in the past?** |  |  |  |  |
|  |
|  |  |  |  |  |
| **How long did you work with them?** |  |  |
|  |  |  |  |  |
| **When did your situation change?** |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| **Working with chemicals/glutaraldehyde/other respiratory sensitisers** |
|  **What type of chemicals are you working with?** |  |  |  |  |
|  |
| **How long have you worked with substances?** |
|  |
|  |  |  |  |  |
| **How many hours per day are you exposed to the substance?** |  |  |
| **What do you use the substance for?** |  |  |  |  |
|  |
|  |  | **Yes** |  | **No** |
| **Is this solely used within a fume hood or safety cabinet?** |  |  |  |  |

**CURRENT WORK RELATED SYMPTOMS**

**Does your work with any of the birds, insects, animals or other types of respiratory sensitisers mentioned cause:**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Yes** |  | **No** |  |  |  | **Yes** |  | **No** |
| **Frequent/Constant sneezing**  |  |  |  |  |  | **Eye Irritation** |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **Runny nose** |  |  |  |  |  | **Chest Tightness** |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **Itchy nose** |  |  |  |  |  | **Wheezing** |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **Blocked nose** |  |  |  |  |  | **Breathlessness** |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **Skin irritation (particularly on hands or face)** |  |  |  |  |

**If you answered YES to any of the above, please give details:**

|  |
| --- |
|  |

**If you answered YES to any of the above, do your symptoms:**

**(Please cross out, or circle, the relevant response)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Usually present** |  | **Day time** |  | **Night time** |
|  |  |  |  |  |  |  |  |  |
| **On days off** |  | **Stay the same** |  | **Improve** |  | **Worsen** |  | **Not applicable** |
|  |  |  |  |  |  |  |  |  |
| **On holiday** |  | **Stay the same** |  | **Improve** |  | **Worsen** |  | **Not applicable** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Yes** |  | **No** |
| **Do you consider your condition to be work related?** |  |  |  |  |
| **If YES give the reasons why you believe the condition is work-related?** |
|  |
|  |
| **Are you involved in other work that requires you to attend Occupational Health for monitoring?** |
|  |  | **Yes** |  | **No** |
|  |  |  |  |  |
| **If YES. Please give details:** |
|  |

**GENERAL HEALTH INFORMATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Yes** |  | **No** |
| **Have you attended your GP for any symptoms relating to eyes, skin, chest****or nose in the last year? (If Yes please give brief details below)** |  |  |  |  |
|  |
|  |
|  |  |  |  |  |
| **Are you in good health at present?** |  |  |  |  |
| **If not, please give details:** |
|  |
|  |  |  |  |  |
| **Do you suffer from asthma?** |  |  |  |  |
| **If YES, please give details:** |  |  |  |  |
|  |
| **What medication are you taking for your asthma?** |  |  |  |  |
|  |
| **Are there any situations or substances that make your asthma worse?****Please give details:** |
|  |
|  |  |  |  |  |
| **Do you suffer from Hay Fever?** |  |  |  |  |
| **What medication are you taking for your Hay Fever?** |
|  |
| **What known allergies do you have?** |
|  |
| **Have you in the past 2 years suffered, or do you currently suffer, from any other chest conditions?** |
|  |  |  |  |  |
| **If YES, please give details, including medication:** |  |  |  |  |
|  |
|  |  |  |  |  |
| **Do you take any other medications on a regular basis?** |  |  |  |  |
| **If YES, please give details** |  |  |  |  |
|  |
|  |  |  |  |  |
| **Do you get short of breath walking with other people of your own age on level ground?** |  |  |  |  |

**GENERAL HEALTH INFORMATION (Continued)**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  | **Yes** |  | **No** |
| **Do you have any other health problems that may affect you in your work?** |  |  |  |  |
| **If YES, please give details:** |
|  |
| **What are your hobbies/leisure activities?** |
|  |
|  |
| **Do you keep pets at home or undertake leisure activities involving birds,****Insects, chemicals or spray paints?** |  |  |  |  |
| **If YES, please give details:** |
|  |
| **Do you smoke?** |  |  |  |
| **If YES, state which type:****(Please circle)** |  | **Cigarettes** |  | **Pipe** |  | **Cigars** |  |  |
|  |  |  |
| **How many years have you smoked?** |  |  |
| **Number per day (or amount of tobacco) daily?** |  |  |
|  |  |  |  |  |  |  |  |  |
| **If No, have you ever smoked?** |  |  |  |  |
| **Date you gave up smoking?** |  |
|  |  |  |  |  |  |  |  |  |
| **Height** |  | **Weight** |  |

**Declaration**

* **I have answered all the questions to the best of my knowledge.**
* **I agree to participate in the health surveillance programme for work induced allergies.**
* **I will report any symptoms of possible reactions to substances encountered in my work to the Occupational Health Unit as soon as possible should I develop these in the future.**

**Signed ......................................................................................... Date ..................................................**

**When completed and signed, this form should be returned to:-**

**Occupational Health Unit, University of Glasgow, 63 Oakfield Avenue, Glasgow, G12 8LP.**

**For Occupational Health Use Only**

|  |  |  |
| --- | --- | --- |
| **Date of Screening:-** |  | **Screened by:-** |
| **Follow up required****Due to Symptoms:-** | **Yes / No** | **Next Review Date:-** |
| **Refer to OPH:-** | **Yes / No** | **Outcome:- Fit/Unfit/Fit with Restrictions** |