

# HEALTH SURVEILLANCE QUESTIONNAIRE

IT IS ACKNOWLEDGED THAT ALL INFORMATION PROVIDED ON THIS DOCUMENT WILL BE TREATED AS CONFIDENTIAL.

## Your Details

Name:

Address:



# SAMPLE

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Occupation	Employer	Period of Employment

If you have employment, have you ever been exposed, or required to wear any of the following?

Please tick the relevant box

Exposure	Yes	No	Comments
Computer screen glare (at work)	<input checked="" type="radio"/>	<input type="radio"/>	
Headline (high)	<input type="radio"/>	<input type="radio"/>	
Industrial noise	<input type="radio"/>	<input type="radio"/>	
Air conditioning	<input type="radio"/>	<input type="radio"/>	
Heat (open air) (at work)	<input type="radio"/>	<input type="radio"/>	
Heating (at work)	<input type="radio"/>	<input type="radio"/>	
Hot (at work)	<input type="radio"/>	<input type="radio"/>	
Work in small office or small room	<input type="radio"/>	<input type="radio"/>	
High level use of mobile	<input type="radio"/>	<input type="radio"/>	

**Do you suffer from any condition that would prevent (or cause an issue with) you from performing an activity or wearing PPE?**

*Please tick the relevant box*

Activity	Yes	No
Wearing personal protective clothing such as boots, glasses and earmuffs etc?	<input type="checkbox"/>	<input type="checkbox"/>
Using respirators — half face, full face or breathing apparatus?	<input type="checkbox"/>	<input type="checkbox"/>
Using electric hand tools or vibration tools?	<input type="checkbox"/>	<input type="checkbox"/>



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Continuing with a condition?

**Do these any activities or PPE not listed above that may cause you an issue?**

Please list below if applicable

**Health condition**

**Are you suffering from a health condition or suffer from the following conditions or diseases?**

Please tick the relevant box

Condition	Yes	No	Condition	Yes	No
Stroke / Cerebral palsy / Dementia	<input type="checkbox"/>	<input type="checkbox"/>	Psychological / Mental	<input type="checkbox"/>	<input type="checkbox"/>
Headaches / Migraine	<input type="checkbox"/>	<input type="checkbox"/>	Heart / Blood pressure / High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis / Osteoporosis / Osteoarthritis / Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory / Lung disease	<input type="checkbox"/>	<input type="checkbox"/>
Neck / Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	Eye / Vision / High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease / Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes / Blood sugar / BMI	<input type="checkbox"/>	<input type="checkbox"/>
Angina / Chest pain / High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Chronic kidney disease / Kidney	<input type="checkbox"/>	<input type="checkbox"/>

Arthritis / Joint Pain?	<input type="checkbox"/>	<input type="checkbox"/>	Breathlessness / Pneumonia?	<input type="checkbox"/>	<input type="checkbox"/>
Eczema / Psoriasis?	<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis / Melanoma?	<input type="checkbox"/>	<input type="checkbox"/>
Injuries / Sports Injury?	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain / Sciatica?	<input type="checkbox"/>	<input type="checkbox"/>
Peptic Ulcer / Gall Stones?	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Bowel Syndrome / Other?	<input type="checkbox"/>	<input type="checkbox"/>



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**Are you currently taking any medication or substance or suffering from any condition that would affect the following?**  
Please tick the relevant box.

Condition	Yes	No	Condition	Yes	No
History/Presence of cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	Psychological/mental	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory/asthma	<input type="checkbox"/>	<input type="checkbox"/>	History of stroke/paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Smoking		Yes	No	Comments	
Do you ever smoke?		<input type="checkbox"/>	<input type="checkbox"/>		
Do you suffer from smoking withdrawal?		<input type="checkbox"/>	<input type="checkbox"/>		
Do you drink alcohol?		<input type="checkbox"/>	<input type="checkbox"/>	If yes, how many standard drinks per week? _____ If drinking daily - please state in _____ units	
Are you or have you ever been a smoker?		<input type="checkbox"/>	<input type="checkbox"/>	If yes, how many cigarettes smoked per week in total? _____ If you've quit when did you? _____	

Do you suffer from any allergies?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, to what?
If yes, do you carry an EpiPen?	<input type="checkbox"/>	<input type="checkbox"/>	.....
If yes, do you have an allergy action plan?	<input type="checkbox"/>	<input type="checkbox"/>	



# SAMPLE

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How do you rate your overall health status over the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	Full access content
How do you rate your overall health status over the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	Full access content
How do you rate your overall health status over the last 3 months?	<input type="checkbox"/>	<input type="checkbox"/>	
How do you rate your overall health status over the last 1 month?	<input type="checkbox"/>	<input type="checkbox"/>	
How do you rate your overall health status over the last 1 week?	<input type="checkbox"/>	<input type="checkbox"/>	
How do you rate your overall health status over the last 24 hours?	<input type="checkbox"/>	<input type="checkbox"/>	

I understand that I have completed the questionnaire accurately and honestly, and will return it to my manager should conditions change.

Name	Signature	Date