HEALTH SURVEILLANCE QUESTIONNAIRE

IT IS ACKNOWLEDGED THAT ALL INFORMATION PROVIDED ON THIS DOCUMENT WILL BE TREATED AS CONFIDENTIAL.	
Your Details	
Name:	
Address:	

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?	☐	☐
Using respirators — half face, full face or breathing apparatus?	☐	☐
Using electric hand tools or vibration tools?	☐	☐

Arthritis / Joint Pain?	☐	☐	Breathlessness / Pneumonia?	☐	☐
Eczema / Psoriasis?	☐	☐	Dermatitis / Melanoma?	☐	☐
Injuries / Sports Injury?	☐	☐	Back Pain / Sciatica?	☐	☐
Peptic Ulcer / Gall Stones?	☐	☐	Irritable Bowel Syndrome / Other?	☐	☐

Do you suffer from any allergies? If yes, to you carry an Epipen? If yes, do you have an allergy action plan?	☐ ☐ ☐	☐ ☐ ☐	If yes, to what? ……