Health questionnaire for on-going surveillance of people potentially exposed to substances that can cause occupational asthma.

To be completed by the responsible person

Employee's name ___________________________ Works no _______________________.

The questionnaire should be completed six weeks after employment commences and annually thereafter on the anniversary of the commencement of employment - unless the company occupational health adviser determines otherwise.

Further advice will be required from the company occupational health adviser if any yes box is ticked.

Since starting your present job have you had any of the following symptoms either at work or at home? (Do not include isolated colds, sore throats or flu.)

(a) Recurring soreness of or watering of eyes    Yes ☐ No ☐
(b) Recurring blocked or running nose    Yes ☐ No ☐
(c) Bouts of coughing    Yes ☐ No ☐
(d) Chest tightness    Yes ☐ No ☐
(e) Wheeze    Yes ☐ No ☐
(f) Breathlessness    Yes ☐ No ☐
(g) Have you consulted your doctor about chest problems since the last questionnaire?    Yes ☐ No ☐

To be completed by the responsible person

(a) No further action required    ☐
(b) Refer to company occupational health adviser    ☐

Signature of responsible person ___________________________ Date ___________________________

I confirm that the responses given by me are correct and that I have received a copy of the completed questionnaire.

Signed ___________________________ Date ___________________________