Initial questionnaire for surveillance of people potentially exposed to substances that cause occupational asthma

To be completed by the responsible person

Company name____

Address____

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In this workplace substances are in use that have been known to cause allergic chest problems. Following the risk assessment under regulation 6 of the Control of Substances Hazardous to Health (COSHH) Regulations 2002, management have decided to carry out a programme of pre-exposure and periodic health surveillance as required by regulation 11 of the COSHH Regulations.

In some cases further advice may be required from the company occupational health adviser.

I understand that a programme of health surveillance is necessary in this employment and will form part of my management health record.

Signature of employee____________________ Date_______________.

Signature of responsible person_____________ Date_______________.

Referred for further investigation ?

Would you please answer the following questions:

1 Surname__________________ Forenames_________________________________

Date of birth____

Home address ____

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____

____

Tel number____

2 Have you any chest problems, such as periods of breathlessness, wheeze, chest tightness or persistent coughing? Yes ☐ No ☐

3 Do you believe that your chest has suffered as a result of any previous employment?

Yes ☐ No ☐

4 Do you or have you ever had any of the following? (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)	Wheezing	Yes ☐ No ☐
(f)	Breathlessness	Yes ☐ No ☐
(g)	Any other persistent or history of chest problems	Yes ☐ No ☐

To be completed by the responsible person

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

Signed (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____________.

Please note: It will be for a health professional to assess the relevance of any respiratory symptoms and to obtain a detailed smoking history as necessary.