HEALTH SURVEILLANCE QUESTIONNAIRE

NAME	
JOB TITLE	
DEPARTMENT	

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):		
	YES	**NO**
1. Recurring soreness of or watering of eyes?		
2. Recurring blocked or running nose?		
3. Bouts of coughing?		
4. Chest tightness?		
5. Wheezing?		
6. Breathlessness?		
7. Have you ever consulted your doctor about chest problems?		

Have you had any of the following symptoms in the last 12 months?		
	YES	**NO**
8. Redness and swelling of fingers or hands?		
9. Cracking of skin on fingers or hands?		
10. Blisters on fingers or hands?		
11. Flaking or scaling of skin on fingers or hands?		
12. Itching of fingers or hands with skin cracks or splits?		
13. Spots, redness, swelling of any other part?		
14. Did these problems last for more than three weeks?		
15. Did these problems occur more than once?		
16. Does your skin get better with periods off work?		
17. Have you lost time from work with skin problems?		

18. Name the substance/material /contact that you think is responsible for any of the above symptoms:	

Signature:	**Date:**

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This page to be completed by the Responsible Person

If the answer is “yes” to any of the questions, employees should be advised to consult their general practitioner.

A copy of this completed questionnaire should be supplied to the employee's general practitioner.

	YES	NO
1. Further action required?		
2. Referral to employees GP?		

Signature of Responsible Person:	**Date:**