OH30/CI

SERCO OCCUPATIONAL HEALTH

BASELINE HEALTH QUESTIONNAIRE
FOR THE CONSTRUCTION INDUSTRY

serco

SECTION 1 - *This section MUST be completed by the requesting Manager* Proposed start date .....

Company/Organisation ..... Contact name .....

Region *(where applicable)* ..... Telephone .....

Business/Division *(where applicable)* ..... Location .....

Job titles ..... Temporary contract ☐ Permanent contract ☐

Job hazards *(please indicate special health hazards which the job is likely to involve)*

Work in excessive noise	☐	Work involving heavy lifting	☐	Working/Escape BA sets	☐
Work using vibratory tools	☐	Work using display screens	☐	Shift work/Night work	☐
Work using skin irritants	☐	Work involving dusty processes	☐	Work at heights	☐
Work using lung irritants	☐	Work involving driving	☐	Work in isolation	☐
Work can be stressful at times	☐	Other *(please specify)*		.....	☐

SECTION 2 - PERSONAL DETAILS *Sections 2 to 9 for completion by employee*

SURNAME ..... FORENAMES .....

Mr/Mrs/Ms/Miss/Title ..... Sex M/F ..... Date of Birth .....

Home address ..... Family doctor .....

..... Address .....

Post Code ..... Telephone home ....

Employee number/ NI number ..... Post Code ..... Telephone .....

DATA PROTECTION ACT 1998

The information you declare on this form will be treated as medical and personal in confidence. It will be viewed only by occupational health staff and securely stored. Access to the information by third parties will require your personal consent. The information will be used to provide an opinion on your fitness for the role for your employer and will include any reasonable adjustments required by established disabilities. By signing this form, you consent to such opinions being provided.

SECTION 3 - JOB HISTORY *(List previous two most recent jobs and employers)*

Job title	Employer	From *(date)*	To *(date)*
.....	.....	.....	.....
.....	.....	.....	.....

Have you been exposed to any of the following hazards in **any** previous job? If so, did you wear personal protection such as gloves/mask?

	Exposed to hazard? *Yes*	*No*	Over what period of time?	Personal protection worn? *Yes*	*No*
Noise	☐	☐	.....	☐	☐
Vibration	☐	☐	.....	☐	☐
Welding/cutting fumes	☐	☐	.....	☐	☐
Asbestos	☐	☐	.....	☐	☐
Radiation	☐	☐	.....	☐	☐
Isocyanates/epoxy	☐	☐	.....	☐	☐
Cement dust	☐	☐	.....	☐	☐
Silica dust	☐	☐	.....	☐	☐
Wood dust	☐	☐	.....	☐	☐
Wood treatments	☐	☐	.....	☐	☐
Other dust	☐	☐	.....	☐	☐

SECTION 4 - PERSONAL HISTORY (*To avoid delays in processing, please give as much information as you can)*

		Yes	***No***	***Details & Dates*** *(Give full information where applicable)*
1.	Do you consider yourself to be in good health?	☐	☐	.....
2.	Have you any disability?	☐	☐	.....
3.	Are you restricted for medical reasons from carrying out any particular type of work?	☐	☐	.....
4.	Have you had an illness or accident in the last three years which caused you to be in hospital?	☐	☐	.....
5.	Have you been in employment at all during the past twelve months? If not, state when you last worked.	☐	☐	.....
6.	Have you been absent from work for any medical reason for more than ten days in the past twelve months?	☐	☐	.....
7.	Have you had to give up a job for medical reasons?	☐	☐	.....
8.	Do you take any form of regular physical exercise?	☐	☐	.....
9.	Are you currently taking any prescribed medication on a regular basis (excluding contraceptive pills)?	☐	☐	.....
10.	Have you consulted your own doctor or any other health practitioner (including physiotherapist, osteopath etc.) during the past three months?	☐	☐	.....

SECTION 5 - SMOKING, ALCOHOL AND DRUGS

	Yes	***No***	
Do you smoke?	☐	☐	
If yes, quantity per day?			Cigarettes ☐ Pipe ☐ Cigars☐
If ex-smoker, how many years since you stopped?			1-5 ☐ 5-10 ☐ 10+ ☐
Do you drink alcohol?	☐	☐	
If yes, what is your average weekly intake?			Pints ..... Shorts ..... Glasses of wine .....

SECTION 6 - MEDICAL HISTORY **Where indicated please complete the supplementary questionnaire and attach by staple to this declaration**

		Yes	***No***	***Details*** *(Give full information where applicable)*
1.	Have you had any heart trouble? e.g. heart attack, angina, operation.	☐	☐	.....
2.	Have you been diagnosed as having high blood pressure or vascular disorder?	☐	☐	.....
3.	Have you had migraine attacks or recurrent headaches?	☐	☐	.....
4.	Have you had a chest disease at any time? E.g. asthma, bronchitis, pneumonia, pleurisy, tuberculosis. *(If yes, complete the respiratory health questionnaire)*	☐	☐	.....
5.	Do you have any allergies or allergic conditions? e.g. hay fever, foods, allergy to animals (give species). *(If yes, complete the respiratory health questionnaire)*	☐	☐	.....
6.	Have you had recurrent indigestion, gastric or duodenal ulcer?	☐	☐	.....
7.	Do you have recurrent diarrhoea or any chronic bowel disease?	☐	☐	.....
8.	Have you had jaundice?	☐	☐	.....
9.	Do you have, or have you had a hernia (rupture)?	☐	☐	.....
10.	Have you had any kidney or bladder trouble? e.g. stone or infection.	☐	☐	.....
11.	Do you have diabetes? If yes, how is it treated?	☐	☐	.....
12.	Have you had persistent or recurrent low back pain? *(If yes, complete musculoskeletal assessment)*	☐	☐	.....
13.	Have you had persistent or recurrent neck/shoulder pain? *(If yes, complete musculoskeletal assessment)*	☐	☐	.....
14.	Have you had persistent or recurrent pain in the arms/ wrists/ hands? *(If yes, complete musculoskeletal assessment)*	☐	☐	.....
15.	Have you had fainting attacks, dizziness spells or blackouts?	☐	☐	.....
16.	Have you been diagnosed as having epilepsy?	☐	☐	.....
17.	Have you received treatment for anxiety/depression or other mental health disorder?	☐	☐	.....
18.	Have you had treatment or support from a psychiatrist, psychologist or counsellor?	☐	☐	.....
19.	Have you had any skin trouble? e.g. eczema, dermatitis, psoriasis or skin allergy. *(If yes, complete the skin assessment questionnaire)*	☐	☐	.....
20.	Do you have any difficulty with colour perception?	☐	☐	.....
21.	Have you any persistent disorder/disease affecting the eyes?	☐	☐	.....
22.	Do you wear spectacles or contact lenses? *(If yes, complete the drivers questionnaire)*	☐	☐	.....
23.	Have you had any ear disease or persistent discharge from either ear?	☐	☐	.....
24.	Do you have any hearing deficiency? *(If yes, complete the audiometry questionnaire)*	☐	☐	If Yes, give cause .....
25.	Have you had any operation?	☐	☐	.....
26.	Do you have reading or writing difficulties? *(If yes, complete the DSE questionnaire)*	☐	☐	.....
27.	Do you suffer with blanching of the fingers on exposure to cold or vibration? *(If yes, complete the HAVS questionnaire)*	☐	☐	.....
28.	Do you have, or have you had any other medical condition not mentioned above?	☐	☐	.....

SECTION 7 - IMMUNISATION HISTORY

Have you received immunisations to the following diseases? Please give year of last dose or booster if known.

		Yes	*No*	*Year*			*Yes*	*No*	*Year*
1.	Poliomyelitis	☐	☐	.....	2.	Tetanus	☐	☐	.....
		☐	☐				☐	☐	

SECTION 8 - WEIGHT/HEIGHT

Weight: ..... Kgs Height: ..... Metres

Body Mass Index [*if known*] = ...

SECTION 9 - DECLARATION

I hereby declare that all medical information given by me to Serco Occupational Health is true and accurate to the best of my belief and knowledge.

Signature of Employee ..... *Date* .....

For office use only:

Date received .....

Comments .....

.....

.....

SECTION 10 - ASSESSMENT *To be completed by the Serco Occupational Health Nurse/Doctor*

FIT FOR SPECIFIED EMPLOYMENT ☐

REFERRED FOR FURTHER OPINION ☐

FIT WITH RESTRICTIONS GIVEN ☐

MEDICAL EXAMINATION REQUIRED ☐

UNFIT ☐

FIT FOR SPECIFIC WORK CATEGORY ☐

Doctor's Signature ..... Doctor's Name *(BLOCK CAPITALS)* .....

Job title ..... Date .....

Nurse's Signature ..... Nurse's Name *(BLOCK CAPITALS)* .....

Post title ..... Date .....

Fitness certificate issued .....