The Royal Bournemouth and Christchurch Hospitals
NHS Foundation Trust
Tel: 01202 704217
occupational.health@rbch.nhs.uk

CONFIDENTIAL HEALTH QUESTIONNAIRE

Please review the information below and **answer all the questions in full** and return along with your vaccination details to **Occupational Health, First Floor Stour Building, Royal Bournemouth Hospital, Castle Lane East, Bournemouth, Dorset BH7 7DW** (failure to do so may result in your clearance being delayed). If you have any queries please ring the Occupational Health Department on the above number.

The purpose of this questionnaire is to ascertain whether you have any health problems that could affect your ability to undertake the duties of your post you have been offered, or place you at any risk in the workplace.

No medical details will be divulged without your permission to any person outside the above Occupational Health Service, but an opinion about your fitness to work will be given to management.

PLEASE USE BLOCK CAPITALS

SECTION 1 –PERSONAL DETAILS

TITLE	Mr/Mrs/Miss/Dr		Male/Female
SURNAME:	PREVIOUS SURNAME:		
FORENAME(S):			
JOB APPLIED FOR:			
WARD/DEPT:	Macmillan Unit Christchurch		
HOME ADDRESS:		D.O.B:	D D / M M / Y Y Y Y
		HOME TEL:	
		MOBILE NO:	
		PREFERRED CONTACT NUMBER	
		EMAIL ADDRESS:	
START DATE:		END DATE IF APPLICABLE:	

SECTION2 – JOB HISTORY

Have you worked for this organisation before Yes/No **If yes, please state when:……**

Please provide details of your previous positions, most recent first

JOB TITLE ORGANISATION		
	FROM:	M M / Y Y Y Y TO: M M / Y Y Y Y
	FROM:	M M / Y Y Y Y TO: M M / Y Y Y Y
	FROM:	M M / Y Y Y Y TO: M M / Y Y Y Y
	FROM:	M M / Y Y Y Y TO: M M / Y Y Y Y

SECTION 3 - GENERAL HEALTH

This section should be completed by all staff.

Please answer the following questions by ticking the YES/NO box and giving dates and details where appropriate.

	DO YOU HAVE/HAVE YOU SUFFERED FROM:	YES	NO	APPROX DATES AND DETAILS
1.	Have you consulted a medical professional in the last 2 years for any physical or mental health problems?			
2.	Are you currently receiving medical treatment or medication?			
3.	Are you awaiting any investigations or treatment of any kind at the moment?			
4.	Do you have any medical condition that affects your ability to work, for example musculoskeletal problems?			
5.	Have you ever been retired on health grounds or received incapacity benefit?			
6.	Have you ever lived/worked abroad?			

If you have answered YES to any of the above, please include full details with dates etc, in section 7

SECTION 4 : IMMUNISATION STATUS

This section should be completed by all staff with direct patient contact.

Please ensure that ALL questions are answered and pathology/vaccination information is included in order to prevent any delay.

Pathology reports and GP printouts/details from occupational health departments are all acceptable but they **MUST** include all information listed below. If you are unable to provide all the information requested you may need to attend the department for assessment.

IMMUNISATION/TEST	YES	NO	DATE	RESULT
Hepatitis B	☐	☐		
Injection no. 1			1.	
Injection no. 2			2.	
Injection no. 3			3.	
				Antibody level =
Blood test	☐	☐		
Booster dose	☐	☐		
Have you ever had chickenpox or shingles?	☐	☐		
If **YES,** was it while living in UK?				
If not, which country were you living in?	☐	☐		
Have you had a **Tuberculin Test** (Heaf, Tine, Mantoux)?	☐	☐		
Do you have a **scar** from a **BCG vaccination**?	☐	☐		
MMR (Measles, Mumps & Rubella)				
Do you have documented history of 2 vaccinations?	☐	☐		
OR	☐	☐		
MMR 1st dose	☐	☐		
MMR 2nd dose	☐	☐		

SECTION 5 – EXPOSURE PRONE PROCEDURES

This section should be completed only by staff who perform exposure prone procedures (EPP). EPP staff includes surgeons, Anaesthetists, Dental staff, Theatre Practitioners, Midwives and ED doctors and nurses.

(EPP – Exposure Prone Procedure are invasive procedures where there is a risk that injury may result in the exposure of the patient's open tissues to the blood of the worker. These include procedures where the worker's gloved hand may be in contact with sharp instruments, needle tips or sharp tissues (include bone & teeth) inside a patient's open body cavity, wound or anatomical space where the hands or fingertips may not be completely visible at all times.)

	EXPOSURE PRONE PROCEDURES:	**YES**	**NO**	**DATES AND DETAILS**
7.	Are you required to undertake EPP's?			
8.	Is this your **FIRST** EPP position in the NHS*? If **NO,** date of first EPP in NHS:			N/A
9.	In the past 5 years have you lived or worked outside the UK for more than 4 weeks?			
10.	Have you **EVER** performed EPP's outside the UK?			N/A
11.	If **YES** to Q.9 or Q.10, in which countries?			

12.	(EPP workers only) Hepatitis B Hepatitis C HIV	☐ ☐ ☐	☐ ☐ ☐	Date	IVS stamped report required

***If you are new to the NHS or you are performing exposure prone procedures for the first time you will be required to have a blood test for HIV, Hepatitis B and C, in line with the Department of Health guidelines. You will need to arrange an appointment to come into the Department, bringing photographic ID (passport/ driving licence)**

SECTION 6: HEALTH SURVIELLANCE (SKIN & LATEX)

This section should be completed by all staff.

It is a requirement of your employment to complete this form. It is imperative to disclose all symptoms. The purpose of health surveillance is to detect symptoms at an early stage so precautionary measures can be adopted with the aim to prevent progression to severe symptoms.

Please answer the following questions by ticking the YES/NO box and giving details where appropriate.

	DO YOU HAVE/HAVE YOU EVER SUFFERED FROM:	**YES**	**NO**	**DATES AND DETAILS**
13.	Asthma	☐	☐	
14.	Hay fever	☐	☐	
15.	Eczema to hands	☐	☐	
16.	Eczema to other areas	☐	☐	
17.	Latex allergy (type I)	☐	☐	
18.	Any other skin conditions	☐	☐	
	WORK INFORMATION			
19.	Are you required to wear gloves?	☐	☐	☐ Latex ☐ Nitrile ☐ Other: ……
20.	Do you wash your hands frequently (more than 20 times per shift) at work?	☐	☐	
21.	Do you wear gloves other than when there is a risk of blood/body fluids or infection reasons?	☐	☐	
22.	Do you come in contact with any other natural rubber products?	☐	☐	
	LATEX GLOVES	**YES**	**NO**	**DETAILS**

23.	**WITHIN THE PAST YEAR,** have you had symptoms after using latex gloves or other latex products?	☐	☐	

24. If **YES** to Q.23, How long after exposure did you have a reaction?
- ☐ During use
- ☐ Immediately after use
- ☐ Within minutes
- ☐ Hours later

25. If **YES** to Q.23, What type of reaction did you have?

☐ Rash to hands	☐ Wheeze/ shortness of breath	☐ Shortness of breath
☐ Itchy/Watery eyes	☐ Itching	☐ Runny nose
☐ Facial swelling	☐ Urticaria (itchy bumps like nettle rash)	☐ Sneezing
☐ Swelling of mouth/lips	☐ Cough	☐ Anaphylaxis (collapse)

26. **WITHIN THE PAST YEAR,** have you had any of the following on either hands or fingers?

☐ Redness/swelling	☐ Cracking of skin	☐ Blisters/spots
☐ Flaking/scaling	☐ Itching	☐ Skin cracks/splits

		YES	NO	DETAILS
27.	If **YES** to Q.26, do you **CURRENTLY** have them?	☐	☐	N/A
28.	Have you been prescribed any treatment?	☐	☐	
29.	Do you have any contact with latex at home?	☐	☐	

HEALTH SURVEILLANCE/COSHH REGULATIONS COMPLIANCE

Completion of Health surveillance is a legal requirement under COSHH Regulations; failure to comply with any stage of surveillance (either not completing this form, not contacting or attending OH when requested) may lead to disciplinary action by your manager.

I have answered all questions to the best of my knowledge. I understand that I have a duty to report possible signs of allergic reactions or skin problems on my hands to the Occupational Health Department as soon as possible. Latex is covered by the COSHH regulations and my manager will be advised of my fitness or any necessary restrictions.

SIGNED:		DATE:											
PRINT NAME:													

SECTION 7: ADDITIONAL MEDICAL INFORMATION

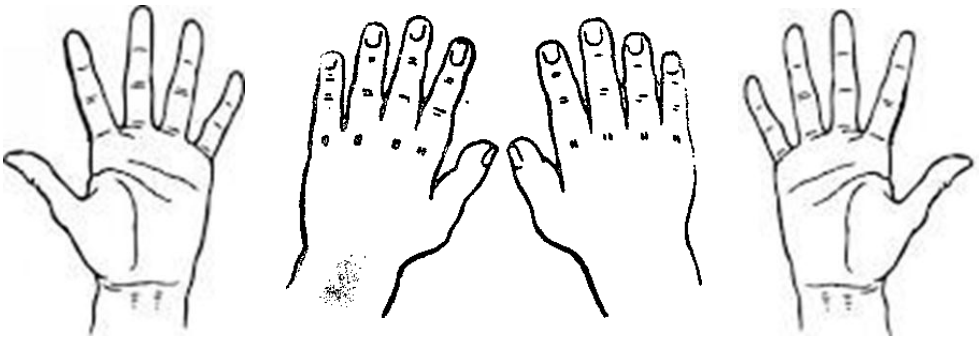
Please use the space below to provide any further details to the Occupational Health Department about any medical conditions you have or have had in the past which you would like to disclose and/or discuss which have not already been covered above.

SECTION 8: DECLARATION												
This section should be completed by all staff.												
Under the Data Protection Act 1998 you are advised that information given on this health declaration form will be held on computer and/or manual records. This will be processed by the Occupational Health staff and will remain confidential within the Occupational Health Service. I hereby testify that the answers given on the questionnaire are true to the best of my knowledge and belief. I understand that I may be required to provide further information and/or attend a consultation. I give my permission for the Occupational Health Service at Royal Bournemouth Hospital to provide details of my vaccinations/blood test results, at my request, to other NHS Trusts who may require this information for the purpose of my employment, and to request these details from other NHS Trusts as necessary.												
SIGNED:		DATE:										
PRINT NAME:												
NAME OF PREVIOUS TRUST WHERE RECORDS HELD/OR GP SURGERY												

FOR OCCUPATIONAL HEALTH SERVICE USE ONLY

INSPECTION OF HANDS

Left Hand
- ❑ Redness
- ❑ Dryness
- ❑ Scaling
- ❑ Crusting
- ❑ Fissures



Right Hand
- ❑ Redness
- ❑ Dryness
- ❑ Scaling
- ❑ Crusting
- ❑ Fissures

LEFT **RIGHT**

OTHER ASSESSMENT NOTES

SECTION 9—TO BE COMPLETED BY OH NURSE/DR ONLY

ACTION FROM QUESTIONNAIRE

- ❑ 1 Fit from Questionnaire
- ❑ 2 Pre-emp interview required--telephone/in person to see OHP/Nurse
- ❑ 3 Imms appointment required
- ❑ 4 Recruitment informed

ASSESSMENT OF OCCUPATIONAL FITNESS

- ❑ A Occupationally fit for this post as at the date below
- ❑ B Occupationally fit with the following adjustments: e.g. alternative gloves or Dermol required as soap substitute.

  ……

  ……
- ❑ C Occupationally fit for this post as at the date below, however a review is recommended within …… months

ASSESSMENT OUTCOME AUTHORISATION

SIGNED:		DATE:	D	D	/	M	M	/	2	0	Y	Y
PRINT NAME:												

Staff Nurse / OHN / OHP