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|  | **Occupational Health Services**  |

**HEALTH QUESTIONNAIRE:**

**CLASSIFIED RADIATION WORKERS IONISING RADIATION REGULATIONS 1999**

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| --- | --- |
| Title (Mr/ Mrs/ Miss/ Ms/ Dr etc) |  |
| Full Name: |  |
| Date Of Birth: |  |
| Address: |  |
| Post Code: |  |
| Telephone Number: |  |
| Department & Contact Tel. Number: |  |
| Line Manager / Supervisor: |  |
| Date Commenced Post: |  |

Please complete the following by indicating a ✓in the appropriate box

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| Are you a ‘classified worker’ under the Ionising Radiation Regulations? |  |  |
| Are you required to undergo medical surveillance because of your work abroad? |  |  |
| Are you required to enter a ‘classified’ area in cases of emergency? |  |  |
| Have you been exposed to radiation during the last year? |  |  |

If **YES**: please give your full details including dose and date if known

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|  | **Dose** | **Date** |
| Occupational Exposure:UKAbroad |  |  |
|  |  |
|  |  |
| Therapeutic Exposure: |  |  |
| Diagnostic Exposure: |  |  |

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| **Family History** |
| Any family history of cancer | **Yes** | **No** |
| If so: Relationship: |  |
| Age at developing cancer (if known) |  |
| Type of cancer |  |

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| --- | --- | --- |
| Do you smoke | **Yes** | **No** |
| If so, how many cigarettes do you smoke per day |
| Alcohol Consumption: How many units do you drink per week(1 pint of beer = normally 2 units, spirits / wine = normally 1 unit | **Units** |

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| **Medical History:** both past and current please provide full details |
| Are you or have you suffered from any form of Malignancy / Cancer | **Yes** | **No** |
| Details (to include medication) |
| Are you or have you suffered from any form of Skin Diseases / Conditions | **Yes** | **No** |
| Details (to include medication) |
| Are you or have you suffered from any form of Blood Diseases / Condition | **Yes** | **No** |
| Details (to include medication) |
| Are you or have you suffered from any form of Chest Diseases / Condition | **Yes** | **No** |
| Details (to include medication) |
| Are you or have you suffered from any Mental Health Disorders / Conditions | **Yes** | **No** |
| Details (to include medication) |
| In the last year have you been exposed to any diagnostic radiation e.g. x rays | **Yes** | **No** |
| If **YES**, please provide further details: |
| Have you had to attend your GP in the past year | **Yes** | **No** |
| If **YES**, please provide further details: |
| Are you currently taking and medication | **Yes** | **No** |
| If **YES**, please provide further details |

I shall inform the Occupational Health Service immediately should my medical circumstances change between the date signed and any further reviews.

The information supplied by you on this questionnaire will be used to produce a certificate. This will be forwarded to your line manager/supervisor as evidence of your fitness to work/study.

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| Name: | Signature: | Date: |

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| **For Occupational Health Use Only:** |
| Fit to work based on te Commenced Postervisorehone ?REagain but will be happy to if required.elp her with strategys load but is also delegating andPaper Screening: | Yes | No |
| Deferred Pending Health Interview / Screening:  | Yes | No |

|  |  |  |
| --- | --- | --- |
| Name: | Signature: | Date: |