**NIGHT WORKERS HEALTH QUESTIONNAIRE**

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| Title: Mr/ Mrs/ Miss/ Ms/ Prof/ Dr: |  |
| Full Name: |  |
| Date of Birth: |  |
| Address: |  |
| Post Code: |  |
| Job Title: |  |
| Department & Contact Telephone Number: |  |
| Name of Line Manager/ Supervisor: |  |
| Contact Tel. No. Line Manager/ Supervisor: |  |
| Date Commenced Post: |  |

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| **Do you currently suffer from or have you ever in the past suffered from any of the following:** | | |
| Diabetes | **Yes** | **No** |
| If ‘YES’ please provide information of control measures e.g. diet controlled, medication or insulin (include dosage and times taken). | | |
| Heart or circulatory problems | **Yes** | **No** |
| If ‘YES’ please provide details including medication (if prescribed). | | |
| Stomach or bowel disorders (particularly where meal times are important) | **Yes** | **No** |
| If ‘YES’ please provide details including medication (if prescribed). | | |
| Sleep difficulties | **Yes** | **No** |
| If ‘YES’ how do you cope and have you seen your General Practitioner | | |
| Chronic chest conditions (especially where night time is troublesome) | **Yes** | **No** |
| If ‘YES’ please provide details including medication (if prescribed). | | |
| Any other health related issue that you feel affects your ability to work night shifts | **Yes** | **No** |
| If ‘YES’ please provide details | | |

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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