**CONFIDENTIAL OCCUPATIONAL HEALTH QUESTIONNAIRE**

**Health Surveillance – Laboratory Form**

Health surveillance for those working with Biological Agents/Genetic Modification/Respiratory Sensitizers including Laboratory Animals/Chemicals/CMR’s/Nanoparticles/Clinical Laboratories

**For staff and postgraduate students please complete the form electronically and e mail to:** [millocchealth@manchester.ac.uk](mailto:millocchealth@manchester.ac.uk)

**For undergraduate students please complete the form electronically and email to:** [waterlooocchealth@manchester.ac.uk](mailto:waterlooocchealth@manchester.ac.uk)

The information supplied by you on this health questionnaire will be used to assess your medical suitability to commence/continue working within laboratory areas and a certificate will be provided and forwarded to your Manager/Supervisor.

**The information you provide will remain confidential to Occupational Health Services.**

For your own health and safety and so that the University can comply with legislation, it is important that your answers are accurate and that you do not withhold any facts.

**Please complete all Sections** and ensure that all relevant details are included as this will help to avoid delays.

**You have a duty to provide all relevant, truthful and accurate information to the University’s Occupational Health Service and no information should be withheld.**

Depending on your answers, the Occupational Health Service may need to contact you for further information. Alternatively, depending on the information disclosed, you may be asked to attend for further screening before we can confirm your medical fitness.

**Signs to look out for in respiratory and/or skin sensitisation/irritation:**

**If you experience any of the following excluding common cold, chest/viral infection, flu or hay fever.**

* Recurring soreness of or watering of eyes
* Recurring blocked or running nose
* Bouts of coughing
* Chest tightness
* Wheezing
* Breathlessness
* Any other persistent or history of chest problems
* Irritation of the skin including itching, cracked, chapping, small blisters, weals or nettle rash.

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| --- | --- | --- | --- | --- | --- |
| Title: Click here to enter text. | Surname: Click here to enter text. | | | First Name: Click here to enter text. | Employee/Student ID No: Click here to enter text. |
| Sex: Click here to enter text. | Address: Click here to enter text. | | | | Date of Birth: Click here to enter text. |
| Job Title/Course: Click here to enter text. | | University email address: Click here to enter text | | | |
| University ext. no: Click here to enter text | | Mobile no: Click here to enter text | | | |
| Department/ Faculty/ School:  Click here to enter text | | Building Name: Click here to enter text. | | | |
| Date Commenced Employment/Course:  Click here to enter text. | | Commencement date of Lab based research:  Click here to enter text. | | | |
| Line Manager’s/Supervisor’s Name:  Click here to enter text.  Email address: Click here to enter text. | | | PG Administrators Name:  Click here to enter text.  Email address: Click here to enter text. | | |

**Please indicate below (type ‘X’) if work/ research involves any of the following hazards:**

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| --- | --- | --- | --- |
| **Biological Agents\*** |  | **Genetically Modified Organisms\*** |  |
| **Clinical** |  | **Nanoparticles** |  |
| **Laboratory Animals** |  | **Laboratory Chemicals** |  |
| **Carcinogens, Mutagens & Reproductive Toxins.**  *Please indicate which reagents below you are working with.* | | |  |
| **H350** may cause cancer (route if relevant): |  | **Please name specific chemicals to be used.** | |
| **H351** suspected of causing cancer (route if relevant): |  |  | |
| **H340** may cause genetic defects (route if relevant): |  |  | |
| **H341** suspected of causing genetic defects (route if relevant): |  |  | |
| **H360** may damage fertility or the unborn child (effect if known, route if relevant): |  |  | |
| **H361** suspected of damaging fertility or the unborn child (effect if known, route if relevant): |  |  | |
| **H362** may cause harm to breast-fed children: |  |  | |
| **H315** causes skin irritation: |  |  | |
| **H317** may cause an allergic skin reaction: |  |  | |
| **H318** causes serious eye damage: |  |  | |
| **H319** causes serious eye irritation: |  |  | |
| Other harmful chemicals (including nanomaterial particles): |  |  | |
| Respiratory sensitizers: |  |  | |
| Schedule 1 poisons: |  |  | |

***NB\*Biological/ GM Details:*** *Please note: that Biological Agents include fixed human tissues and body fluids (e.g. blood) and any micro-organisms, cell culture, or human endoparasite which may cause infection, allergy and toxicity or otherwise create a hazard to human health.*

Please answer **ALL** the following questions. If **YES**, it is important to give accurate and detailed information below including dates, medication and ongoing or current treatment required. Do not include any symptoms associated with colds or any other respiratory infections.

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| Do you have any of these symptoms before, during or after work? | | | | | |
|  | Yes | No |  | Yes | No |
| Breathlessness |  |  | Chest tightness/Wheezing |  |  |
| Shortness of breath when resting? |  |  | Irritation or soreness of throat |  |  |
| Episodes of waking up at night with breathlessness or a tight chest? |  |  | Blocked nose, nasal catarrh or bouts of sneezing |  |  |
| Asthma/Bronchitis/Persistent dry cough |  |  | Red, sore, watery or itchy eyes |  |  |
| Early morning cough/phlegm production |  |  | Eczema, psoriasis, dermatitis, skin rashes, irritation or flaky skin. Wheals following animal scratches |  |  |
| **If yes to above please give details**: Click here to enter text. | | | | | |
|  | | | | Yes | No |
| Do the symptoms improve at the weekend or when you are away from work? | | | |  |  |
| Have you suffered with any of the above symptoms in the past year? Click here to enter text | | | | | |

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| Are you allergic to any of the following? | Yes | No | |  | Yes | No |
| Anything you are exposed to at work |  |  | Medication | |  |  |
| Dust mite |  |  | Food | |  |  |
| Tree or grass pollen |  |  | Animal fur or feathers | |  |  |
| **If yes to above please give details**: Click here to enter text. | | | | | | |
| Have you ever been diagnosed with a laboratory animal allergy? | | | | | Yes | No |
| **If yes to above please give details**: Click here to enter text. | | | | | | |
| Are you taking any medication for any ongoing breathing, nasal or eye condition? | | | | | Yes | No |
| **If yes to above please give details**: Click here to enter text. | | | | | | |
| Do you smoke? | | | | | Yes | No |
| Have you ever smoked? | | | | | Yes | No |
| Do you vape use cigarettes? | | | | | Yes | No |

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| Please indicate clearly whether you have been vaccinated against the following or whether you have had the disease? If you have previously supplied vaccine information just give details of any recent vaccinations. |

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| **MMR (Measles, Mumps and Rubella) / Varicella (Chicken Pox)** Please specify: | | | | | | | | | | | | | | | | | | | |
| **I have had the following disease(s):** | | **Yes** | | **No** | **Don’t Know** | | | **I have received the following vaccinations:** | | | | **Yes** | | **No** | **Date Received:** | | | | |
| Measles: | |  | |  |  | | | Measles: | | | |  | |  | Click here to enter text. | | | | |
| Mumps: | |  | |  |  | | | Mumps: | | | |  | |  | Click here to enter text. | | | | |
| Rubella: | |  | |  |  | | | Rubella: | | | |  | |  | Click here to enter text. | | | | |
|  | | | | | | | | MMR (please note that 2 are required): | | | |  | |  | 1. Click here to enter text.  2. Click here to enter text. | | | | |
| Chicken Pox: | |  | |  |  | | | Varicella: | | | |  | |  | Click here to enter text. | | | | |
| **Hepatitis B:** Please **X** as applicable**: Yes No** | | | | | | | | | | | | | | | | | | | |
| Are you currently working with human tissue, blood or bodily fluids? | | | | | | | | | | | | | | | | |  | |  |
| Or/Are you expecting to work with human tissue, blood or bodily fluids? | | | | | | | | | | | | | | | | |  | |  |
| Have you ever been offered Hepatitis B vaccinations? | | | | | | | | | | | | | | | | |  | |  |
| If **YES** please provide the following dates and details: | | | | | | | | | | | | | | | | | | | |
| **Date of 1st Dose**  Click here to enter text. | **Date of 2nd Dose**  Click here to enter text. | | | | | **Date of 3rd Dose**  Click here to enter text. | | | **Date of blood test**  Click here to enter text. | | | | | **Result of blood test lµ/l**  Click here to enter text. | | | | **Date of Booster**  Click here to enter text. | |
| **Hepatitis A:** Please **X** as applicable: **Yes No** | | | | | | | | | | | | | | | | | | | |
| Have you ever been offered Hepatitis A vaccination? | | | | | | | | | | | | | | | | |  | |  |
| **Date of 1st Dose**  Click here to enter text. | | | | | | | | | | **Date of 2nd Dose**  Click here to enter text. | | | | | | | | | |
| **Other Vaccinations: Dates Of Vaccinations:** | | | | | | | | | | | | | | | | | | | |
|  | | | 1st | | | | 2nd | | | | 3rd | | 4th | | | Booster | | | |
| Pertussis  Whooping Cough | | | Click here to enter text. | | | | Click here to enter text. | | | | Click here to enter text. | |  | | |  | | | |
| Polio | | | Click here to enter text. | | | | Click here to enter text. | | | | Click here to enter text. | | Click here to enter text. | | | Click here to enter text. | | | |
| Tetanus | | | Click here to enter text. | | | | Click here to enter text. | | | | Click here to enter text. | | Click here to enter text. | | | Click here to enter text. | | | |
| Diphtheria | | | Click here to enter text. | | | | Click here to enter text. | | | | Click here to enter text. | | Click here to enter text. | | | Click here to enter text. | | | |
| Pneumococcal | | | Click here to enter text. | | | |  | | | |  | |  | | |  | | | |
| Influenza | | | Click here to enter text. | | | | Click here to enter text. | | | | Click here to enter text. | | Click here to enter text. | | | Click here to enter text. | | | |
| BCG Bacillus Calmette Guerin | | | Click here to enter text. | | | |  | | | |  | |  | | |  | | | |

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| **Data Protection Information:**  This questionnaire will form the basis of your Occupational Health (OH) record.   * Records are held in confidence by Occupational Health Services.   A certificate of fitness is provided to your Manager/Supervisor in order to provide evidence of your fitness to commence/continue employment/studies.   * No identifiable medical or other information you provide in confidence and contained in your Occupational Health record will be released by Occupational Health Services to anyone else without your consent being obtained. * You may obtain access to your Occupational Health record by contacting Occupational Health Services. * If you require further information contact Occupational Health Services , 4th floor, Crawford House, Booth Street East, Manchester, M13 9QS Tel: 0161 306 5806. * The University of Manchester will not share your information with any third party. For further information of your rights to access data which we hold about you please contact the Records Management Office telephone 0161 275 8111 and e mail [dataprotection@manchester.ac.uk](mailto:dataprotection@manchester.ac.uk) * The University of Manchester Occupational Health Services do not consider email to be a secure method for communicating sensitive personal data as it can be intercepted and read by third parties during transit. If you do correspond with us by email, we will take this to mean that you understand and accept this risk. |

**Declaration**

**I confirm that the information provided is true and accurate to the best of my knowledge.**

**I shall inform the Occupational Health Services immediately should my medical circumstances change.**

**Following consideration of your completed health questionnaire it may be required that you will be asked to attend Occupational Health Services. This may be to enquire further into information disclosed.**

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| **Name:** | **Signature:** | **Date:** |

***Thank you for completing the form***

**REMEMBER TO LOOK OUT FOR SYMPTOMS ASSOCIATED TO YOUR WORKING ENVIRONMENT AND CONTACT OCCUPATIONAL HEALTH SERIVICES IF YOU HAVE ANY CONCERNS.**

**TO BE COMPLETED BY OCCUPATIONAL HEALTH SERVICES:**

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| **Comments:** |  | |
| **Fit To Continue with current role/study:** | **YES** | **NO** |
| **Refer to Occupational Health Physician:** | **YES** | **NO** |
| **Signature:** | **Date:** | |