UNIVERSITY OF CAMBRIDGE

OHF32

Occupational Health

CONFIDENTIAL

Health Assessment Questionnaire for Night Workers

Surname: ..... Mr / Mrs / Miss / Ms / Dr / Prof / Other:

First names: ..... Date of Birth: ..... Age: .....

Job title: ..... Supervisor: .....

Home tel: ..... Work tel: .....

Mobile: ..... Email: .....

Data Protection Information

The information that you supply on this questionnaire will be held in confidence by the University Occupational Health Service as part of your occupational health record. For full details of how your personal information is used by the University Occupational Health Service, please see http://www.oh.admin.cam.ac.uk/general-information/confidentiality-statement

Please specify your weekly hours of work / shift pattern .....

The following medical conditions could possibly affect your health and ability to safely carry out night work, or could be made worse by night work.

Do you suffer from any of these conditions?	**Yes**	**No**
a) Diabetes?	☐	☐
b) Heart or circulatory problems?	☐	☐
c) Stomach or intestinal problems, such as ulcers?	☐	☐
d) Any medical condition which causes difficulty sleeping?	☐	☐
e) Chronic chest disorders where night time symptoms may be particularly troublesome?	☐	☐
f) Any medical condition requiring medication on a strict timetable?	☐	☐
g) Any medical condition where the timing of meals is particularly important?	☐	☐
h) Any mental health problems which may be affected by night work?	☐	☐
i) Any other medical condition which may affect your ability to work safely at night?	☐	☐
j) Are you a new or expectant mother? (optional question)	☐	☐
k) If you have worked at night before, did this cause any ill health?	☐	☐

If '*yes'* to any of the above, please give details i.e., when condition developed, is this new, how severe, its effect on you, how well controlled and treatment so far.

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Do you believe that any of these are made worse by night work? Yes☐ No☐ If *'yes'*, please give details:

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Would you like to discuss these with an Occupational Health Adviser? Yes☐ No☐

Declaration

I certify that all the answers given above are true to the best of my knowledge and belief. I understand that no medical details will be divulged without my permission to any person outside Occupational Health, but an opinion about my fitness for night work will be issued to management.

Signed: ..... Date: .....

For occupational health use only

Suitable to continue night working			Yes ☐ No ☐
Requires OHA telephone review			Yes ☐ No ☐
Requires OHA night worker health assessment			Yes ☐ No ☐
Requires OHP referral			Yes ☐ No ☐
Recall date:	Annual ☐	2 years ☐	3 years ☐

OHA signature_____Date_____

Stamp_____