UNIVERSITY OF CAMBRIDGE

OHF08

CONFIDENTIAL

Occupational Health

Staff working with Respiratory/Skin Sensitisers – Initial Assessment

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

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

National Insurance number: .....

Status: Research staff / Technical staff / Undergraduate / Postgraduate / Academic Visitor / Other

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

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

Department: ..... Internal tel: .....

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

1. Employment History

	At the University of Cambridge	In your career
How long have you worked with respiratory/skin sensitisers? – *e.g., chemicals, dust, fumes, other substances etc*.		
Have you previously undergone health surveillance?		

2. Work Information

Which respiratory/skin sensitisers are you working with? – *please list below (refer to COSHH risk assessment)*

Name of substance	
Frequency of use	
Duration on each occasion	
Description of work	
What control measures are in place – *e.g., fume cupboard, LEV etc*.?	
What personal protective equipment (PPE) is worn?	

3. Medical History

Please answer all the following questions. If 'yes' please give dates and details.

Have you ever been affected by:	**Yes**	**No**	**Date and Details**
Asthma or recurrent bronchitis?	☐	☐	.....
Allergic rhinitis or conjunctivitis?	☐	☐	.....
Hayfever?	☐	☐	.....
Eczema / dermatitis?	☐	☐	

4. Do you have or have you ever experienced any of the following symptoms since working with respiratory sensitisers? *Do not include isolated colds, sore throats, flu or chest infections.*

If 'yes' please give dates and details.	Yes	No	Date and Details
Recurring blocked or running nose	☐	☐	.....
Watery, itchy eyes	☐	☐	.....
Bouts of coughing	☐	☐	.....
Wheezing / difficulty in breathing	☐	☐	.....
Chest tightness	☐	☐	.....
Do you use an inhaler to help you breath?	☐	☐	.....
Do you smoke?	☐	☐	If yes how many? .....
Are you an ex-smoker	☐	☐	If yes when did you stop? .....

5. Do you have or have you ever experienced any of the following skin symptoms since working with skin irritants/sensitisers?	**Yes**	**No**
Redness, itching and/or burning (tingling) sensation	☐	☐
Rash or spots (Hives)	☐	☐
Blisters	☐	☐
Flaking or scaling of the skin	☐	☐
Cracks or splitting of the skin	☐	☐
Symptoms of dermatitis / eczema on your hands or forearms?	☐	☐
If you have any of these symptoms do they tend to subside in periods where you are not working	☐	☐

6. If you no longer work with respiratory/skin sensitisers when did you stop and why?

Date: ..... Reason: .....

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.....

6. Declaration

I certify that all the answers given above are true to the best of my knowledge and belief.

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

For OHS use only

Health Assessment

Name:		Age:		Height:	
Dept:		Date/time:			

Occupational history:

Allergy history:

Respiratory history:

Skin: Dermatitis: (history / current) General condition:

Family allergy history:

Social history: (Relevant hobbies / exercise)

Information discussed		**Leaflets given:**	
Risk factors	☐	HSE 'Breathe Freely'	☐
Exposure controls	☐	Mask face fit testing (if applicable)	☐
Signs and symptoms of allergy	☐	Skin care leaflet (OHL08)	☐
Reporting symptoms - respiratory / skin to manager and OH	☐	HSE 'It's in Your Hands' leaflet	☐
Health surveillance	☐	Gloves (chemicals-HSD168C)	☐

Outcome

Suitable to work with respiratory/skin sensitisers	Yes☐	No☐	Discuss with SOHA, any positive symptoms / concerns	Yes☐	No☐
Spirometry within normal parameters	Yes☐	No☐			
Skin check satisfactory	Yes☐	No☐	Discuss with OHP	Yes☐	No☐
Routine 3 month recall	Yes☐	No☐	OHP appt	Yes☐	No☐
Routine 6 month recall	Yes☐	No☐	OHP appt arranged	Yes☐	No☐
Routine annual recall	Yes☐	No☐	RAST test	Yes☐	No☐
Refer for mask face fit test	Yes☐	No☐	*Please specify which:*……..		

Enhanced health surveillance: 3 months ☐ 6 months ☐ 12 months ☐

☐ other *(Please specify)*

OHT/Clinic nurse / OHA signature:		Print name / stamp:	

OCCUPATIONAL HEALTH RECORD

CONTINUATION SHEET

Supervisor

Contact details

GP

Surname

First Name(s) Date of Birth Sex

Job title

Contact number(s)

Email

Date / time	