OpusHealth

HEALTH ASSESSMENT FOR NIGHT WORKERS

This questionnaire is to be treated as Medical in Confidence. Information obtained is to be evaluated by health professional staff only.

Name

Date of Birth:

Address

Job Title

Main Duties:

No of Hours Worked per night:

No of Hours Worked per 24 hours:

If yes is answered to the following questions, please give details and dates:

Do you or have you ever suffered from :

Heart Disease	☐ Yes	☐ No	
Respiratory Disease	☐ Yes	☐ No	
High Blood Pressure	☐ Yes	☐ No	
Diabetes (Insulin dependent) If yes please detail medication timetable	☐ Yes	☐ No	
Epilepsy If yes please detail medication timetable	☐ Yes	☐ No	
Stomach or Intestinal disorders	☐ Yes	☐ No	
Impaired hearing	☐ Yes	☐ No	
Impaired eyesight	☐ Yes	☐ No	
Any psychiatric or psychological condition Requiring regular medication	☐ Yes	☐ No	
Does your particular sleep pattern mean you are at your best: In the morning (lark)	☐ Yes	☐ No	
At the end of the day (owl)	☐ Yes	☐ No	
Do you take any regular medication of any kind If yes please give details	☐ Yes	☐ No	

DECLARATION

I declare that the information given is true to the best of my knowledge.
I understand that I may be required to attend for consultation and physical examination if so requested by the Occupational Health Adviser.
I understand the form will be retained by the Occupational Health Adviser. Further medical information may be requested from my doctor if considered necessary, and subject to my consent.

Signature:

Date: