INITIAL CONSULTATION FOR SPIROMETRY

Company: Site:

Name: Date of Birth:

Address:

Postcode: Telephone number:

Job Title Mobile number:

Reason for Referral:

Main Tasks undertaken at work/exposures:

Previous job roles, including any exposures (noise, dust, chemicals)

OpusHealth

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Social History:

Current Health

Past Health:

Family History:

Exercise:

Hobbies:

Allergies:

Medication:

Respiratory Symptoms:

Shortness of breath	☐ Yes	☐ No
Tightness of chest	☐ Yes	☐ No
Wheeze	☐ Yes	☐ No
Runny/blocked nose	☐ Yes	☐ No
Runny/itchy eyes	☐ Yes	☐ No
Cough	☐ Yes	☐ No
Cold	☐ Yes	☐ No
Sore throat	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No
Hayfever	☐ Yes	☐ No
Are you a smoker?	☐ Yes	☐ No
Have you been a smoker?	☐ Yes	☐ No

If you have been a smoker how many per day and for how long?

Skin Symptoms:

Eczema	☐ Yes	☐ No
Psoriasis	☐ Yes	☐ No
Dermatitis	☐ Yes	☐ No
Urticaria	☐ Yes	☐ No

Symptoms at work that get better at home/holiday?

Any musculoskeletal/joint problems:

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PPE Use:	Used	Not Used
Mask	☐	☐
Goggles	☐	☐
Gloves	☐	☐
Coveralls	☐	☐
Safety Shoes	☐	☐
Ear Defenders	☐	☐

Other:

Employee Declaration

I consent to undertaking a Spirometry Examination and a standard pro-forma being provided to management confirming the results of this examination.

Additional consent will be obtained should any result of this examination need to be discussed with Management.

By ticking this box ☐ you are signing an agreement to the following statements:
I declare that all the foregoing statements are complete and true to the best of my knowledge.

Signature:

Date: