Questionnaire for Occupational Health Checks – Confidential!

Surname: ....

Given Name: ....

Date of Birth: ....

....

Home Address: ....

....

Phone Number: ....

Job Position: ....

Employer ....

Employer's Address ....

....

Your appointment on: at hours

Please bring the following with you to the appointment:

☒ Official Document (identity card or passport)

☒ Vaccination documents (if any)

☒ Latest laboratory results (if any)

☒ Glasses or other visual aids (if any)

☒ This questionnaire

If you are unsure about answering individual questions, please leave them unanswered. Open questions can be be clarified in conversation with the doctor.

❒ Please do not eat anything two hours before the appointment/ Drink only water or tea without sugar.

At the request of your employer, an occupational health examination will be carried out on you due to occupational health screening or due to the necessity of a suitability check for a certain activity. The purpose of this examination is to identify individual health risks arising from your occupation and thus to protect you personally or to determine whether you are suitable for a certain occupation. To do this, we need information about your medical and occupational history, among other things.
Your details are subject to medical confidentiality and will not be disclosed to your employer or third parties under any circumstances.

Please answer the following questions by ticking the appropriate box and underlining or completing where necessary.

I. Personal medical history (tick as appropriate and underline if YES or complete in writing)	**YES**	**NO**
• Do you have or have you ever had any occupational health problems? ______	❒	❒
• Have you had accidents that resulted in permanent injuries? ______	❒	❒
• Do you have a severe disability? Cause and degree of disability (GdB) in % ______	❒	❒
Do you suffer or have you suffered from the following diseases? Diseases of the		
• Eyes (e.g. short-sightedness, long-sightedness, loss of vision, blindness, glaucoma, cataract) ______	❒	❒
• Ears (e.g. hearing loss, tinnitus, dizziness) ______	❒	❒
• Thyroid gland (e.g. hyperfunction, hypofunction, goiter) ______	❒	❒
• Cardiovascular system (e.g. heart attacks, CHD, high blood pressure, stroke, heart rhythm disorders) ______	❒	❒
• respiratory system (e.g. asthma, COPD, tuberculosis, pneumonia, obstructive sleep apnoea) ______	❒	❒
• Liver, gall bladder, pancreas (e.g. viral hepatitis, gall stones, pancreatitis) ______	❒	❒
• Stomach, intestines (e.g. ulcers, chronic inflammatory bowel disease, reflux disease, esophagitis) ______	❒	❒
• Kidneys, bladder (e.g. kidney stones, urinary tract infections, bladder incontinence) ______	❒	❒
• Spine (e.g. intervertebral disc disease, chronic back pain) ______	❒	❒
• Joints (e.g. rheumatism, arthrosis) ______	❒	❒
• Nervous system (e.g. dizziness, chronic headaches, migraine, epilepsy, depression, brain injuries) ______	❒	❒
• Metabolic diseases (e.g. diabetes, gout, hypercholesterolaemia) ______	❒	❒
• Skin (e.g. neurodermatitis, psoriasis, eczema) ______	❒	❒

	YES	NO
• Hay fever, allergies - if YES, against:____:	❒	❒
• Other chronic diseases or health disorders: ____	❒	❒
• Inpatient hospitalisation (e.g. operations, accidents) - if YES, type of operation and when. ____	❒	❒

II. Family history: (diseases in the family)	YES	NO
• e.g. hypertension, coronary artery disease, myocardial infarction, stroke, asthma, diabetes, cancer ____	❒	❒

III. Current health condition:	YES	NO
• Do you currently feel healthy and symptom-free? If NO, what complaints do you have? ____	❒	❒
• Are you currently receiving medical treatment? If YES, for: ____	❒	❒
• Do you take medication regularly? If YES, state name(s) and dosage: ____	❒	❒
• Do you take drugs? If YES, which ____	❒	❒
• Do you smoke? If YES, how many cigarettes per day _____, for how many years________________	❒	❒
• How many days a week do you drink alcohol? ❒ daily, ❒ every 2nd day ❒ 2-3 days/weak ❒ 1-2 days/week ❒ 1 day/week ❒ never		
• WOMEN only: last period: _________________ Are you pregnant? ❒ yes ❒ questionable ❒ no		
• When was the last X-ray chest examination? ____________________ Where?		

IV. Questions about infection control: You only need to answer these questions if you come into contact with food in the course of your work, i.e. if you produce, handle or place food on the market and come into contact with it directly (by hand) or indirectly via utensils (e.g. crockery, cutlery, etc.).	YES	NO
• Do you suffer from an infectious diarrhoeal disease (especially typhoid, paratyphoid, cholera, shigella dysentery, salmonellosis) or viral hepatitis A or E or is there a suspicion of one of these diseases?	❒	❒
• Has the examination of a stool sample revealed the excretion of pathogenic germs (in particular salmonella, shigella, cholera or so-called enterohaemorrhagic Escherichia coli bacteria)?	❒	❒
• Do you suffer from an infected wound or a contagious skin disease?	❒	❒

V. For health care workers and workers in areas at risk of infection (outdoor workers, delegates to tropical destinations etc.):

- Have you been vaccinated against the following diseases and if YES, when was the last vaccination (year)?

Hepatitis A ❒ _________	Tetanus ❒ _________	Poliomyelitis ❒ _________	Rubella ❒ _________
Hepatitis B ❒ _________	Diphtheria ❒ _________	Measles ❒ _________	FSME ❒ _________

- Infectious diseases already contracted, e.g. childhood diseases (measles, mumps, rubella, chicken pox, whooping cough), hepatitis diseases, etc./results of the last laboratory tests (e.g. anti-HBs, anti-HCV, anti-HIV antibodies, etc.)?

  ____
  ____

- When was the last tuberculin test carried out? ________ test result: ❒ positive ❒ negative

- I hereby declare that I have answered all questions relevant to the assessment of my state of health, especially those concerning physical and mental illnesses/restrictions, truthfully and to the best of my knowledge.
- I consent to the electronic storage of my data.
- All information is subject to medical confidentiality. I must give my written permission for the data to be passed on.

____________________ _______________ ____

Place Date Signature