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Medical Screening Questionnaire for Occupational Health Checks (page 1/2) – confidential!

Surname: ----------

Given name: ----------

Date of birth: ----------

Home address: ----------

Phone number: ----------

Job description: ----------

Employer: ----------

Employer's Address ----------

Your Appointment on: **at** **hrs**

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 (completed)!

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

In case that your check includes a blood test:
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? – if yes, which? _____	❒	❒
• Have you had accidents that resulted in permanent injuries? _____	❒	❒
• Do you have a disability? Cause and degree of disability (GdB) in % _____	❒	❒
• Is there a reduction in earning capacity according to German law? (MdE) in % _____	❒	❒
Do you suffer or have you suffered from the following diseases? Diseases of the		
• Eyes (e.g. short-sightedness, blindness, glaucoma, cataract) _____	❒	❒
• Ears (e.g. hearing loss, tinnitus, dizziness) _____	❒	❒
• Thyroid gland (e.g. hypo-/hyperfunction, nodules, goiter) _____	❒	❒
• Cardiovascular system (e.g. heart attack, CHD, blood pressure, stroke, arrhythmia) _____	❒	❒
• Respiratory system (e.g. asthma, COPD, obstructive sleep apnoea) _____	❒	❒
• Liver, gall bladder, pancreas (e.g. viral hepatitis, gall stones, pancreatitis) _____	❒	❒
• Stomach, intestines (e.g. ulcers, CID, reflux disease) _____	❒	❒
• Kidneys, bladder (e.g. kidney stones, renal failure, UTIs, incontinence) _____	❒	❒
• Spine (e.g. intervertebral disc disease, chronic back pain)_____	❒	❒
• Joints (e.g. rheumatism, arthrosis, joint replacement) _____	❒	❒
• Nervous system (e.g. dizziness, headaches, epilepsy, depression, brain injuries) _____	❒	❒
• Metabolic diseases (e.g. diabetes, gout, hypercholesterolaemia) _____	❒	❒
• Skin (e.g. neurodermatitis, psoriasis, eczema, varicose veins) _____	❒	❒
• Other health disorders, allergies: _____	❒	❒
• Inpatient hospitalisation (e.g. operations, accidents) - if YES, type of operation and when. _____	❒	❒

Medical Screening Questionnaire for Occupational Health Checks (page 2/2) - condidential!

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/ symptoms 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 ☐ 2-3days/week ☐ 1-2 days/week ☐ 1 day/week ☐ never
- Height: _____ (m) Weight: _____ (kg) Last Chest-X-ray/CT-Scan examination (year)? _____
- WOMEN only: date of last menstruation _____ Are you pregnant? If yes, which week _____ ❒ ❒

IV. Questions regarding infection control: **YES** **NO**

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.).

- 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 employees in other areas at risk of infection (e.g. outdoor workers, tropical destinations):

- Have you been vaccinated against the following diseases? If YES, when was the last vaccination (month/year, eg 07/2018)?

  Hepatitis A ❒ _____ Tetanus ❒ _____ Polio ❒ _____ Rubella ❒ _____

  Hepatitis B ❒ _____ Diphtherie ❒ _____ Measles ❒ _____ FSME ❒ _____

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

  _____

  _____

- Date of the last tuberculin test? (eg. 07/01/2022): _____ test result: ☐ positiv ☐ negativ

- 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