SOUTH GLOUCESTERSHIRE OCCUPATIONAL HEALTH SERVICES
OCCUPATIONAL ASTHMA INITIAL QUESTIONNAIRE

Initial questionnaire for surveillance of people potentially exposed to substances that cause occupational asthma

To be completed by the responsible person

Company name: ____

Address: ____

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In this workplace substances are in use that have been known to cause allergic chest problems. Following the risk assessment under regulation 6 of the Control of Substances Hazardous to Health (COSHH) Regulations 2002, management have decided to carry out a programme of pre-exposure and periodic health surveillance as required by regulation 11 of the COSHH Regulations.

In some cases further advice may be required from the company occupational health adviser.

I understand that a programme of health surveillance is necessary in this employment and will form part of my management health record.

Signature of employee Date .

Signature of responsible person Date

Referred for further investigation? Yes No

Please answer the following questions:

1 Surname Forename(s)______________________________________

Date of birth ____

Home address____

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Tel number ____

2 Have you any chest problems, such as periods of breathlessness, wheeze, chest tightness or persistent coughing? Yes No

3 Do you believe that your chest has suffered as a result of any previous employment?

Yes No

4 Do you or have you ever had any of the following? (Do not include isolated colds, sore throats or flu.)

(a)	Recurring soreness of or watering of eyes Recurring	Yes	No
(b)	blocked or running nose	Yes	No
(c)	Bouts of coughing	Yes	No
(d)	Chest tightness	Yes	No
(e)	Wheezing	Yes	No
(f)	Breathlessness	Yes	No
(g)	Any other persistent or history of chest problems	Yes	No

To be completed by the responsible person

(a)	No further action required	Yes	No
(b)	Refer to company occupational health adviser	Yes	No

Signed (responsible person) ______________________ Date ____________.

I confirm that the responses given by me are correct and that I have received a copy of the completed questionnaire.

Signed ______________________________________ Date ____________.

Please note: It will be for a health professional to assess the relevance of any respiratory symptoms and to obtain a detailed smoking history as necessary.