Baseline Health Screening for people potentially exposed to substances that can cause allergic occupational skin or chest disease (sensitising agents)

Name:	Date of Birth:
Department:	Job Title:
Work Tel:	Email:

1. Have you had previous occupational exposure to respiratory or skin sensitisers such as latex or laboratory animals?	
a.	☐ No (if no go to 4)
b.	☐ Yes

If "Yes"

2. What sensitising agents have you been exposed to at work?[1]	**What year did you first start this type of work?**
☐ Latex	
☐ Sensitising chemicals	
☐ Laboratory animals Please state types	
☐ Flies	
☐ Possibly any type; (e.g. maintenance worker)	
☐	

3. Have you ever suffered from any of the following whilst at work or on a work day evening? (if yes, please give details)		
Recurring blocked or runny nose or sneezing	☐ YES ☐ NO	
Chest tightness, wheezing or asthma	☐ YES ☐ NO	
Itching, redness or swelling of the skin, eczema or dermatitis	☐ YES ☐ NO	
Recurring itchy, sore or watering eyes	☐ YES ☐ NO	

4. Do you have a history of: (if yes, please give details)		
Asthma or any other chest condition	☐ YES ☐ NO	
Eczema or dermatitis	☐ YES ☐ NO	
Hay fever	☐ YES ☐ NO	
Any allergies	☐ YES ☐ NO	
An anaphylactic reaction	☐ YES ☐ NO	

[1] Please add any categories not stated in the space provided

5. Do you take regular medication	☐ YES ☐ NO	
6. Have you ever been diagnosed with or had to give up or stop work due to allergy or sensitisation	☐ YES ☐ NO	
7. Do you smoke	☐ YES ☐ NO	
8. Do you have regular contact with household pets	☐ YES ☐ NO	
9. Do you have any hobbies that may cause exposure to dust, fumes or solvents	☐ YES ☐ NO	

The information on this questionnaire is used by the OH Service to assess risk of occupational ill health related to work with laboratory allergens and will not be used for any other purposes. I understand that following my appointment for baseline screening, my employer will be notified of the outcome but that specific medical details will remain confidential in my Occupational Health Record. If you require information on accessing your OH records please ask your nurse.

Signature: **Date:**

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Outcome	**Level of screening**	**Recall due**
☐ Satisfactory ☐ Satisfactory Hand Inspection ☐ Refer to Occupational Physician ☐ Action required (adjustments advised) ☐ Symptom Assessment Required ☐ Symptom Advice Given	☐ Low Level ☐ High Level	☐ 6 weeks ☐ 3 months ☐ 6 months ☐ 12 months
Signature of OHA:	**Date:**	