

[SUGGESTED] QUESTIONNAIRE FOR EMPLOYEES EXPOSED TO RESPIRATORY SENSITISERS

*Please print throughout this questionnaire – thank you*

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| Part 1 – your personal details  |
|  |
| **Surname:**  |  | **Forename(s):** |  |  |
| **Date of birth:****(DD/MM/YYYY)** |  | **National Insurance No:** |  |  |
| **Employee number:** |  | **Current job title:**  |  |  |
| **Start date (MM/YYYY):**  |  | **Current dept and location:** |  |  |
|  |
| **Exposure to potential respiratory sensitisers *(self-complete or choose from list):*** |  |
|  |  |  |
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| Part 2 – your health  |
|  |
| 1. Since starting work at [x] (*or* over the past 12 months), has your chest ever felt tight or your breathing become difficult? (please tick) -  | *Yes:*  |  | *No:*  |  |  |
|  |
| 2. Since starting work at [x] (*or* over the past 12 months), has your chest ever sounded wheezy or whistling? (please tick) - | *Yes:*  |  | *No:*  |  |  |
|  |
| 3. If ‘yes’ to 1 or 2, in what year (month) did you first notice this? | *Year:*  |  | *Month:* |  |  |
| i. What happens to this on days off or on holidays of two days or more? (please tick below) - |
|  | *It gets better:* |  | *It stays the same:*  |  | *It gets worse:* |  |  |
|  |
| ii. Do you get this on contact with anything at work? (please tick) - | *Yes:*  |  | *No:*  |  |  |
|  |
| - If ‘yes’, what? (please state) - |  |  |
|  |
| iii. Do you get this on contact with anything at home? (please tick) - | *Yes:*  |  | *No:*  |  |  |
|  |
| - If ‘yes’, what? (please state) - |  |  |
|  |
| 4. Since starting work at [x] (*or* over the past 12 months), has your nose been blocked, itchy, runny or sneezing?  | *Yes:*  |  | *No:*  |  |  |
|  (Do not count the times you were ill with colds or ‘flu.) |  |
|  |
| 5. Since starting work at [x] (*or* over the past 12 months), have your eyes been itchy or runny? (please tick) - | *Yes:*  |  | *No:*  |  |  |
|  |
| 6. If ‘yes’ to 4 or 5, in what year (month) did you first notice this? | *Year:*  |  | *Month:* |  |  |
| i. What happens to this on days off or on holidays of two days or more? (please tick below) - |
|  | *It gets better:* |  | *It stays the same:*  |  | *It gets worse:* |  |  |
|  |
| ii. Do you get this on contact with anything at work? (please tick) - | *Yes:*  |  | *No:*  |  |  |
|  |
| - If ‘yes’, what? (please state) - |  |  |
|  |
| iii. Do you get this on contact with anything at home? (please tick) - | *Yes:*  |  | *No:*  |  |  |
|  |
| - If ‘yes’, what? (please state) - |  |  |
|  |
|   |

*Continued overleaf …/*

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| *[Questions* 7 *and* 8 *below are optional – may be useful for protein allergens (such as flour)]* |
| 7. Since starting work at [x] (*or* over the past 12 months), have you had itchy bumps on your arms, hands or face? (do not count insect bites or stings). | *Yes:*  |  | *No:*  |  |  |
|  |
| 8. If ‘yes’, in what year (month) did you first notice this? - | *Year:*  |  | *Month:* |  |  |
| i. What happens to this on days off or on holidays of two days or more? (please tick below) - |
|  | *It gets better:* |  | *It stays the same:*  |  | *It gets worse:* |  |  |
|  |
| ii. Do you get this on contact with anything at work? (please tick) - | *Yes:*  |  | *No:*  |  |  |
|  |
| - If ‘yes’, what? (please state) - |  |  |
|  |
| iii. Do you get this on contact with anything at home? (please tick) - | *Yes:*  |  | *No:*  |  |  |
|  |
| - If ‘yes’, what? (please state) - |  |  |
|  |
|  |
| 9. Since starting work at [x] (*or* over the past 12 months), have you been told you have any of the following (please tick all that apply; however, if you’re not sure, tick ‘No’) |  |
| i. Asthma: | *Yes*  |  | *No*  |  | *- If ‘yes’, in what year?*  |  |  |
|  |
| ii. Hayfever: | *Yes*  |  | *No*  |  | *- If ‘yes’, in what year?*  |  |  |
|  |
| iii. Urticaria (nettle rash, hives) | *Yes*  |  | *No*  |  | *- If ‘yes’, in what year?*  |  |  |
|  |
| *[Question* 10 *is optional]* |
| 10. Do you have any other health problems?  | *Yes:*  |  | *No:*  |  |  |
|  |
| - If ‘yes’, what are they? -  |  |  |
|  |
|  |
|  |
| Part 3 – Spirometry  |
| 11. Spirometry measurements |
|  | *Measured* | *Predicted* | *% predicted* | *(SE)* | *Change (ml)**from last test* | *Date of last test**(if available)* |  |
| FEV1 |  |  |  |  |  |  |  |
|  |
| FVC |  |  |  |  |  |  |  |
|  |
| FEV1/FVC |  |  |  |  |  |  |  |
|  |
| PEF  |  |  |  |  |  |  |  |
|  |
|  |
| 12. Height (cm):  |  | Ethnicity:  |  |  |
|  |
| 13. Current smoking  | *Yes*  |  | *No*  |  | *- If ‘yes’, state total pack/years:*  |  |  |
|  |
|  |
| Part 4 – Final section |
|  |
| **Signature:**  |  | **Comment:** |  |  |  |  |
| **Designation:**  |  |  |  |  |  |  |
| **Action:**  |  |  |  |
| **Date:**  |  |  |  |  |  |  |
|  |

*This questionnaire was created by the Department of Occupational and Environmental Medicine*

*at Royal Brompton Hospital, London SW3*

