[Royal Brompton and Harefield NHS Foundation Trust](http://www.rbht.nhs.uk/)

[SUGGESTED] QUESTIONNAIRE FOR EMPLOYEES EXPOSED TO RESPIRATORY SENSITISERS

*Please print throughout this questionnaire – thank you*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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):*** | | | | |  |
|  |  | | | |  |
|  | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 …/*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| *[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*

