**strictly confidential upon completion**

**Night Workers Health Assessment Questionnaire**

In accordance with the Working Time Regulations 1998, the purpose of the questionnaire is to ask whether you have any health problem that could be affected by night work, so that where necessary an appropriate medical review can be arranged. The questionnaire is confidential and we will only use the information within for the arrangements for your health and safety at work.

Please complete the form and tick the appropriate box for the questions listed; if you have any other condition that you believe should be considered, please write brief details at the bottom of the page or continue on a separate sheet of paper.

Home Manager:

|  |  |  |
| --- | --- | --- |
| **Name:** | **Yes** | **No** |
| Have you had any medical problem in the past that has prevented you from working at night? |  |  |
| Do you have diabetes, thyroid, or gland problems? |  |  |
| Do you have a history of blackouts, fits, or epilepsy? |  |  |
| Do you have angina or any other heart problems? |  |  |
| Do you have/have you had a stomach ulcer? |  |  |
| Do you have/ have you had a continuing bowel problem? |  |  |
| Do you have any chronic chest problem such as asthma, emphysema or bronchiectasis? |  |  |
| Do you have any recurrent or continuing sleep disturbance? |  |  |
| Are you currently waiting for or receiving treatment from your GP or a consultant in relation to an on-going health condition? |  |  |
| Do you have any other health problem that affects your fitness for night work? |  |  |
| Are you taking any prescribed medications on a long-term basis? |  |  |
| If you have answered yes to any of the above questions please provide further details. |  |  |
| Would you like to undertake a full Night Worker Health Assessment? |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Employee Signature: |  | | Date: |  |
| Reviewed by Home Manager: |  | | Date: |  |
| Follow up required? | Yes / No |