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| --- | --- | --- | --- |
| **Health assessment questionnaire** | **Yes** | **No** | **N/a** |
| Have you had any medical problem in the past that has prevented you from working at night? |   |   |   |
| Are you diabetic? |   |   |   |
| Are you subject to angina, or other heart problems that may affect your fitness? |   |   |   |
| Have you had duodenal or stomach ulcers in the past, or are you under treatment for those at present? |   |   |   |
| Have you had any continuing bowel problem, for instance following major surgery? |   |   |   |
| Do you have any chronic chest problem such as asthma, emphysema or bronchiectasis? |   |   |   |
| Do you have any disability affecting mobility that will cause difficulties in arranging night work? |   |   |   |
| Do you have any recurrent or continuing sleep disturbance requiring medical advice? |   |   |   |
| Are you having specialist care requiring your attendance at hospital clinics for treatment? |   |   |   |
| Do you have any other health problem that affects your fitness for night work? |   |  |  |
| Are you taking any medication to a strict timetable? |   |  |  |
| Please give the names of any prescribed medications that you take regularly: |   |  |  |
| Please give any further details that you would like to bring to our attention: |   |  |  |

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_