

UCL Human resources

Occupational Health & WELLBEING

**HEALTH QUESTIONNAIRE FOR NIGHT WORKERS**

|  |  |
| --- | --- |
| NAME:       | MOBILE:       |
| DEPT:       | DOB:       |

Please consider the questions below. Have you EVER experienced or been diagnosed with *(please circle):*

|  |  |
| --- | --- |
| 1. Seizures / blackout or epilepsy?
 | YES [ ]  NO [ ]  |
| 1. Digestive disorder that requires you to take regular meals on medical advice?
 | YES [ ]  NO [ ]  |
| 1. Chronic chest disorders especially if night time symptoms?
 | YES [ ]  NO [ ]  |
| 1. Diabetes?
 | YES [ ]  NO [ ]  |
| 1. Significant sleep disorder requiring treatment? Any condition which causes difficulty sleeping?
 | YES [ ]  NO [ ]  |
| 1. High blood pressure or cardiac problems?
 | YES [ ]  NO [ ]  |
| 1. Mental health issues including alcohol or drug problems?
 | YES [ ]  NO [ ]  |
| 1. Medical condition requiring medication to a strict timetable?
 | YES [ ]  NO [ ]  |
| 1. Any health factors which might affect fitness for night work or might be affected by night working?
 | YES [ ]  NO [ ]  |
| If YES to Q 1-9 please give details here:       |

I declare that I have answered the questions on this form honestly and fully and that I am not otherwise aware of any physical or mental disability that will or may affect my ability to work night shifts. I understand that my employer will be notified of my fitness for night shift work, and that my medical information will remain confidential to OH. I understand that I now have the option of being referred to occupational health for further assessment. In signing this health questionnaire

**I do wish to exercise my right to a health assessment***.*  [ ]

**I do not wish to exercise my right to a health assessment** **[ ]**

|  |  |  |
| --- | --- | --- |
| PRINT NAME:       | SIGNATURE:       | DATE:       |