QUESTIONNAIRE FOR MEDICAL FITNESS FOR WIND TURBINE WORK

First name		**Last name**	
Date of Birth		**Sex at birth**	

Telephone number	
Address	

Employer	
Job role	

Type of work – E.g. onshore/offshore	
Additional tasks – E.g. Medical response/firefighting	
Method of transport to workplace	

Date of initial examination	
Date of follow-up examination	

Date of last examination		**By whom**	

Restriction/outcome:

MEDICAL HISTORY ***please circle/tick***

a) Do you have any current health problems, have you seen a doctor or had hospital treatment since your last assessment?	YES	NO

If yes, please give details:

b) Are you currently on any medication, tablets, ointments or other treatments?	YES	NO

If yes, please give details:

c) Have there been any changes in personal health patterns, e.g. in smoking, drinking, weight, sleeping more/less, changes in diet, etc. in the last year?	YES	NO

If yes, when, how long and for what?

d) Have you had any sickness absence in the past year?	YES	NO

If yes, when, how long and for what?

e) Have you had any operations or significant illnesses, ever, in the past?	YES	NO

If yes, please give details:

f) Is there a history of illness in your family, particularly diabetes, heart disease, blood pressure, stroke, cancer, blood disorder?	YES	NO

If yes, please give details:

g) Have you ever changed jobs, retired, or been advised not to drive on health grounds?	YES	NO

If yes, please give details:

h) Are there any reasons you should not, or feel you may be incapable of, performing shift work, climbing ladders, entering confined spaces, bending, lifting or carrying loads, or doing strenuous physical work?	YES	NO

If yes, please give details:

GENERAL HEALTH

Since your last assessment have you experienced any of the following?

	YES	NO		YES	NO
Skin rashes or persistent sores?			Diabetes, epilepsy?		
Sudden change in vision, double vision?			Fear of heights or enclosed spaces?		
Swelling, lumps, aches or pains in breast, testicles, armpits, groin?			Anxiety, depression, nervous or mental illness, drug or alcohol problems?		
Palpitations or irregularity in your heartbeat, high blood pressure?			Have you attempted suicide, self harm in the past?		
Problems with stamina, or tolerating heat?			Loss of appetite, reduced concentration, moody or irritable?		
Allergies?			Any back or neck pains, joint pains or stiffness?		
Unintentional or unexplained weight loss?			Problems with agility or balance?		
Difficulty hearing?			Problems with strength, dexterity, grip, reach or awkward postures?		
Pain in your abdomen, gastric problems?			Persistent cough or coughed up blood?		
Changes in bowel habit, diarrhoea, constipation?			Vomiting or vomited blood?		
Asthma, wheezing or shortness of breath?			Persistent headache or migraine?		
Pain or tightness in chest?			Pain or difficulty urinating, increased frequency?		
Fits, faints, dizziness, giddiness, blackouts or loss of consciousness for any reason – knocked out/head injury/passed out?			Changes in sleeping pattern, difficulty sleeping, unusually early wakening?		
Vertigo?			Visual problems or colour blindness?		
Dyslexia?			Drug or alcohol problems?		
Asthma?			Sea sickness?		

I declare that all the information I have given on this form is correct to the best of my knowledge.

Full name:	
Signature:	
Date:	