INVESTIGATION QUESTIONAIR COMPRESSED AIR WORKERS

Hefting
Medische keuringen

Name		Town	
Initials		Telephone number	
Date of birth		Employer	
Male/Female			
Adress		Function	

HEALTH GENERALLY

Have you ever had or do you currently have...		YES	NO
1	Pain or restrictions in movement of the lower limb (hip, knee ankels, feet)		
2	Pain or restrictions in movement of the upper limb (shoulder, elbow, wrist, arm , hands)		
3	Pain or restrictions in movement of the back spinal cord or neck		
4	Shortness of breath		
5	Stomach or bowel problems		
6	Chestpain while excersising		
7	Psychical problems: (Irritatable, feeling down, (concentrationproblems, sleepdisorder)		
8	Blackouts or fainting (full/partial loss of contiousness)		
9	Sleepiness, tiredness, drowsy		
10	Skin problems (f.e. excema, mycosis)		
11	Visual problems		
12	Hearing problems		
13	Do you smell allright		

TREATMENTS

Have you ever had or do you currently have an investigation of, or undo treatment for:		YES	NO
1	Complaints of the lower limbs, upper limbs, back or nek		
2	Breathing problems		
3	Complaints of the heart, vessels, blood pressure		
4	Diabetes mellitus, epilepsy		
5	Alcohol and/or drugproblems		
6	Psychological problems,		
7	Skin deseases		
8	Less of visual faculty		
9	Less of hearing		
10	Do you suffer or health problems, while being in a cold environment?		

		JA	NEIN
11	Are you allergic?		
	If yes what kind of allergy?		
12	Did you use during the past years medication for a longer period?		
	If yes which medication?		
13	Do you use medication on this moment?		
	If yes which medication?		
14	Behavioral health, mental or psychological problems (panic attack, fear of closed or open spaces)?		
15	Do you suffer of any disease or defect which can cause problems while you are excercising your future function/job?		

HABBITS		**YES**	**NO**
1	Do you have reguarly physical excersise?		
2	How many hours on a weekly base?		
3	Did you smoke in the past?		
4	Dou you still smoke?		
	If yes how much?		
5	Do you consume more then 25 glases of alcohol during a week		
6	Do you have a family hystorie of:		
	High bloodpressure		
	Heart desease, blood, vessel problems		
	Diabetes		

WORKING CONDITIONS		**YES**	**NO**
1	Do you have a job with maximal physical excersise?		
2	Can you speak of an unsafe working area?		
3	Do you suffer from a lot of noise during your work?		
4	Are you working with toxic materials?		
	If yes which materials?		
5	Are you working with breathprotection?		
	If yes what kind of protection?		

PLACE	DATE
SIGNATURE	