STUDENT HEALTH DEPARTMENT UNIVERSITY COLLEGE CORK

RESPIRATORY & SKIN SENSITISOR QUESTIONNAIRE

Last Name: **First name:** **Date Of Birth:**

Mobile Telephone No. **e-mail address**

Department: **Student No:** **Date:**

This form is required so the Student Health Department can assess your risk profile in respect of any potential contact with respiratory sensitisers in connection with laboratory or other research work. Please answer the following questions as accurately as you can. Please give an estimate if you are unsure of an answer or consult with your supervisor. Medical information provided in the questionnaire will be kept in strict confidence by the Student Health Department and only shared with others with your consent.

See www.ucc.ie/en/studenthealth/services/coursehealth/ for further information

1	Location of potential contact with respiratory sensitiser? (Please specify the laboratory or other work/ressearch location(s) where exposure to a respiratory sensitisor is anticipated)	1 2 3
2	What is the nature of the respiratory sensitiser you will be/are in contact with?: (e.g. chemical, laboratory animal antigen, pollen etc)	1 2 3
3	How long will you be/are you in contact per day?	Hours
4	How frequently will you be/are you potentially in contact?	
5	What month/year Did **OR** Will contact with sensitisers start	Month: Year:
6	How many weeks/months or years do you expect your lab work will last. (Please give expected end-date of lab work)	Weeks/Months/Years: End- Date:
7	Have you had previous contact with respiratory sensitisers? If yes please give brief details: No ☐ Yes ☐	
If you will be/are potentially in contact with laboratory animal antigen please answer the following:		
8	What species of animal will you be/are you in contact with?	
9	What is the level of contact? (see below for guidance)	1 ☐ 2 ☐ 3 ☐ 4 ☐
	Level 1 No direct contact but enters animal facility Level 2 Does not conduct procedure on live animals but handles unfixed animal tissues and fluids Level 3 Minor exposures (handles, restrains, collection of specimens or administer substances to live animals) Level 4 Major exposures (performs invasive procedures, cleans animal facilities)	
	Signed:	**Date:**

Grid below To be completed by Student Health Department Physician only

Is Health Surveillance (HS) required?			No ☐	Yes ☐	Date next HS due		No Followup
Referal for specialist opinion	No ☐	Yes ☐	Next HS Requires:		Questionnaire only ☐ Questionnaire and PFT ☐		DNA x 2 ☐ Discharge ☐
Dr Michael Byrne MCRN 11130			**Signature:**			**Date:**	

	Medical type	Additional risk Present*	Questionnaire only	Questionnaire and lung function tests	Interval to next medical
1	Pre- placement	No		Recommended	6 months
2	Pre- placement	Yes		Recommended	3 months
3	Health surveillance	No	Recommended		1 year
4	Health surveillance	Yes		Recommended	6 months

**Additional Risk Present: Hx or current asthma, allergic rhinitis,atopy or sensitisation to domestic or lab animals*

STUDENT HEALTH DEPARTMENT UNIVERSITY COLLEGE CORK

RESPIRATORY & SKIN SENSITISOR QUESTIONNAIRE

RESPIRATORY QUESTIONNAIRE

Please tick Yes or No to the following questions:

				YES	NO
1.	If you get a cold does it usually go to your chest?			☐	☐
2.	Have you ever had any chest illnesses that have kept you off work, indoors, or in bed for a week or more?			☐	☐
3.	Did you have lung problems as a child (under 10 yrs)?			☐	☐
4.	Have you ever suffered any of the following: (Please Circle the any of the condition names below that apply to you)			☐	☐
PLEASE CIRCLE IF APPLY	**Asthma:**	Do you still have it?	Yes ☐ No ☐		
		Are you on treatment?	Yes ☐ No ☐		
		At what age did the first attack occur?			
	Bronchitis:	Do you still have it?	Yes ☐ No ☐		
		Are you on treatment?	Yes ☐ No ☐		
		At what age did the first attack occur?			
	Pneumonia:	At what age did the first attack occur?			
	Hay Fever/ Sinusitis/ Rhinitis:	Do you still have it?	Yes ☐ No ☐		
		Are you on treatment?	Yes ☐ No ☐		
		At what age did the first attack occur?			
	Emphysema:	Do you still have it?	Yes ☐ No ☐		
		Are you on treatment?	Yes ☐ No ☐		
		At what age did the first attack occur?			
5.	Did you ever suffer from Eczema?			☐	☐
6.	Did you ever have an operation on your chest?			☐	☐
7.	Did you ever injure your chest?			☐	☐
8.	When did you last have a chest x-ray?			☐	☐
9.	Did you ever have any other tests done on your lungs?			☐	☐
10.	Do you usually have a cough?			☐	☐
	If yes:	Do you cough every morning?	Yes ☐ No ☐		
		Do you cough every day?	Yes ☐ No ☐		
		For how long have you had this cough?			
11.	Do you usually or often bring up phlegm (sputum)?			☐	☐
	If yes:	Does this occur every morning?	Yes ☐ No ☐		
		Does it occur every day?	Yes ☐ No ☐		
		For how long has this occurred?			
		Does it occur for more than 3 months every year?	Yes ☐ No ☐		

STUDENT HEALTH DEPARTMENT UNIVERSITY COLLEGE CORK

RESPIRATORY & SKIN SENSITISOR QUESTIONNAIRE

					Yes	No
12.	Does your chest ever sound wheezy or whistling?				☐	☐
	If yes:	Does it occur when you have a cold?	Yes ☐	No ☐		
		Does it occur after exercise?	Yes ☐	No ☐		
		Does it occur on most days or nights?	Yes ☐	No ☐		
		Have you ever required treatment?	Yes ☐	No ☐		
		Has it ever made you breathless?	Yes ☐	No ☐		
		Does it ever occur immediately after work?	Yes ☐	No ☐		
		How long have you had this complaint?				
13.	Do you get short of breath when hurrying on the level or walking up a slight hill?				☐	☐
14.	Do you ever have a stop for breath when walking on the level at your own pace?				☐	☐
15.	Do you get breathless at work?				☐	☐
16.	Do you get breathless with other activities?				☐	☐
	If yes, please give details:					
17.	Did you ever cough up blood?				☐	☐
18.	Have you ever smoked cigarettes?				☐	☐
	If yes:	Do you smoke now?	Yes ☐	No ☐		
		How old were you when you started?				
		How old were you when you stopped?				
		How many do you smoke?				
		Do/did you inhale the smoke?	Yes ☐	No ☐		
19.	Have you smoked a pipe regularly?				☐	☐
	If yes:	Do you now smoke a pipe?	Yes ☐	No ☐		
		How much tobacco do you smoke?				
		Do/did you inhale the smoke?	Yes ☐	No ☐		
20.	Have you smoked cigars?				☐	☐
	If yes:	Do you smoke now?	Yes ☐	No ☐		
		How many do you smoke?				
		Do/did you inhale the smoke?	Yes ☐	No ☐		
21.	Were you ever treated for Tuberculosis (TB) or Sarcoidosis?				☐	☐
22.	Did you ever have severe chest infections?				☐	☐
23.	Do you suffer from recurrent conjunctivitis?				☐	☐
24.	Do you have any allergies?				☐	☐
25.	Do you suffer from any breathing problems at work?				☐	☐
26.	Have you ever found it difficult to breathe while at work or immediately afterwards?				☐	☐

STUDENT HEALTH DEPARTMENT UNIVERSITY COLLEGE CORK

RESPIRATORY & SKIN SENSITISOR QUESTIONNAIRE

SKIN QUESTIONNAIRE

Please tick Yes or No to the following questions:

Do you have or have you ever had in the past	Yes	No	Details
Asthma? Hay fever? Eczema? Hives? Psoriasis?	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	
Dry or chapped skin?	☐	☐	
Any ulcers on your skin?	☐	☐	
"Wheals" on skin after scratches from animals?	☐	☐	
Change in the colour of any areas of your skin?	☐	☐	
Bad dandruff?	☐	☐	
Skin testing for allergies or skin disease?	☐	☐	
Treatment for any skin condition?	☐	☐	
A problem wearing woolen clothing?	☐	☐	
A rash due to any substance in a previous job?	☐	☐	
An allergy or sensitisation to any substance in a previous job?	☐	☐	
A rash from: Cosmetics/perfume Jewellery Medications	☐ ☐ ☐	☐ ☐ ☐	
Blisters on the side if your fingers?	☐	☐	
Excessive palm sweating?	☐	☐	
Skin "breaking out" from time to time?	☐	☐	
A family history of: Allergies (food, pollen) Asthma, hay fever, eczema? Psoriasis? Other skin problems?	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	
Hobbies that involve skin contact with chemicals?	☐	☐	
Do you use gloves or creams at work?	☐	☐	
Do you work with anything that affects your skin?	☐	☐	

Signed: _____ **Date:** _____

References

1. Guidelines on Occupational Asthma, Health and Safety Authority (HSA), 2008
2. Occupational Asthma-Identification, Management and Prevention, British Occupational Health Research Foundation (BOHRF), 2010