# Health Questionaire

# Night Workers

**Name:** …… **Date:** ……..

**Sex:** **M** **F** **Height** ……

**Weight (KG)** …….

**Home Phone;** ……. **Mobile:** ……..

**Address:** ……
……

**Doctors Name and Address:** ……
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**Person to call in case of an emergency:**

**Relationship:** ……. **Phone Number:** …….

**Are you taking any medication or drugs? If so what:**
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**Have you any medical condition that may prevent you from working at night:**
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**Have you any medical condition that may prevent you from working alone safely?**
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**What type of exercise do you partake in?**
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Do You have or have you had in the last five years Please circle

1. History of heart problems, chest pain or stroke yes / no
2. Increased blood pressure yes / no
3. Any chronic illness or condition yes / no
4. Difficulty with physical exercise yes / no
5.Advice from physician not to exercise yes / no
6. Recent surgery (last 12 months) yes / no
7.Prenancy ( now or within the last 3 months) yes / no
8. History of breathing or lung problems yes / no

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|---|---|
| 9. Muscle , joint, or back disorder or any previous unjury still affecting you | yes / no |
| 10. Diabetes or thyroid condition | yes / no |
| 11. Cigarette smoking habit if so how many do you smoke per day | yes / no |
| 12. Obesity ( more than 20% over ideal body weight) | yes / no |
| 13. Increased blood cholesterol | yes / no |
| 14.History of heart problems in the immediate family | yes / no |
| 15. Hernia or any condition that may be aggravated by lifting weight | yes / no |
| 16. Rapid or runaway heart beat | yes / no |
| 17. Skipped heartbeat | yes / no |
| 18. Rheumatic fever | yes / no |
| 19. Has your doctor ever said your blood pressure was too high | yes / no |
| 20. Shortness of breath | yes / no |
| 21. Phlebitis or embolism | yes / no |
| 22. Stroke | yes / no |
| 23. Do you frequently have pains in your heart and chest | yes / no |
| 24. Has your physician ever said you have heart trouble | yes / no |
| 25. Do you often feel faint or have spells of severe dizziness? | yes / no |
| 26. Are you over the age of 65 | yes / no |
| 27. Are you unaccustomed to vigorous exercise | yes / no |
| 28. Has your doctor ever told you that you have a bone or joint problem that has been or could be made worse by exercise | yes / no |
| 29. Recent hospiltalization for any cause. List specifics | yes / no |
| 30.Orthopedic problems ( including arthritis) list specifics | yes / no |
| 31. Problems with eyesight (including colour vision), hearing and sense of smell. If answering yes please give details below | yes/no |

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Please explain any yes answers or comments
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Date: …… Signature ……

Date:…… Witness Signature ……