HEALTH CHECK CHART

GENERAL DATA

First name _____ Last name _____

Personal Identification Code: ☐☐☐☐☐☐☐☐☐☐☐

Phone number: _____

Name and address of the employer: _____

_____

Occupation: _____

E-mail address: _____

Work experience in current position _____ Total work experience _____

The main risk factors for this medical examination:

☐computer work (____ of work), ☐working in heights (above 1,2m), ☐working with chemicals, ☐noise, ☐manual handling of loads, ☐forced positions, ☐forced movements, ☐psycho-emotional tension, ☐shift work, ☐night shifts, ☐work with electrical equipment, ☐vibration

Additional risk factors: _____

Job description: _____

_____

_____

_____

_____

Personal protective equipment at work: ☐gloves, ☐protective work clothing, ☐ protective footwear, ☐safety ear muffs, ☐safety earplugs, ☐respirator, ☐glasses,

_____

Previous employers (2 most recent):

Name of the employer	Occupation	The beginning and ending of employment	Risk factors at work

First name _____ Last name _____

Personal Identification Code: ☐☐☐☐☐☐☐☐☐☐☐

EMPLOYEE HEALTH DECLARATION

Please give Your answers in **WORDS (YES or NO) ON EACH LINE**. If „Yes“, please specify the health problem and give the year or Your age when You were first diagnosed.

Do You currently have or have ever had any of the following illnesses?	**Yes/No**	**Details (What and when?)**
- pulmonary disorders (incl. tuberculosis)		
- cardiovascular disease		
- elevated blood pressure (hypertension)		
- allergias		
- gastrointestinal disorders incl. ulceritis, gallstones		
- liver disorders incl. hepatitis		
- kidney disorders, urinary tract disorders		
- endocrine disorders incl. diabetes, thyroid disorders		
- rheumatic disorders (joint disorders)		
- pains in the neck, back and/or shoulder regioon		
- numbness and discomfort of the hands during night		
- traumas (bone fractures, accidents)		
- operations		
- loss of consciousness, epilepsy, seizures		
- psychological disorders. Are You taking and medication for psychological disorders?		
- Do You use glasses or contact lenses?		
- eye disorders		
- chronic rhinitis (running nose), sinusitis		
- ear disorder, incl. problems with balance		
- skin disorders		
- blood disorders		
- other diseases / disorders		
What narcotics have You used?		
How often do You consume alcohol?		☐daily ☐ weekly ☐ monthly ☐ less often
How much do You smoke?		___ cigarettes daily for ___ years ☐ I have quit smoking
Do You take any medications on a regular basis? What medication?		
Have You been on sick leave in the past year?		
Have You ever been hospitalized?		
Have You ever been subject to restrictions on work due to a medical examination?		
Do You have any health issues that You associate with Your work or Your work environment?		

Your family doctor is _____

I confirm the accuracy of the data.

Employee signature _____ Date _____

Pursuant to the „Personal Data Protection Act“ („Isikuandmete kaitse seadus“), Your health data will not be transferred to third parties.