**MEDICAL IN CONFIDENCE**

 **HEALTH SCREENING QUESTIONNAIRE FOR WORKERS USING VIBRATING TOOLS AND MACHINERY**

**To be completed by Employee/ Potential Employee**

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| --- | --- | --- | --- |
| **Name** |  | **Date of birth** |  |
| **Job location** |  | **Job title** |  |
| **Address** |  | **Telephone number** |  |

Your role involves using vibrating tools and or machinery and as your Employer we need to protect you against health risks associated with using this type of equipment. To assist us with this we need to ask you some medical related questions. Depending upon your answers an appointment may be made to see our occupational health provider to discuss the answers on this questionnaire and your health issues in private.

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| --- | --- |
| **Previous exposure, please answer the following:** | **Yes/ No** |
| Have you ever used hand-held vibrating tools, machines or hand fed processes in your previous jobs? |  |
| **If Yes:** |
| Year of first exposure? |  |
| When was the last time you used them? |  |
| Details of vibrating tools used and why? |  |

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| **If previously used/ currently using vibrating tools, please answer the following:** | **Yes/ No** |
| Do you have any tingling of the fingers lasting more than 20 minutes after using vibrating equipment? |  |
| Do you have tingling of the fingers at any other time? |  |
| Do you wake at night with pain, tingling and/ or numbness in your hand or wrist? |  |
| Do one or more of your fingers go numb more than 20 minutes after using vibrating tools? |  |
| Have your fingers gone white (clear discolouration of the fingers with a sharp edge, usually followed by a red flush) on cold exposure?If yes, do you have difficulty rewarming them when leaving the cold? |  |
| Do your fingers go white at any other time? |  |
| Are you experiencing any other problems with the muscles or joints of the hands or arms? |  |
| Do you have difficulty picking up very small objects, e.g. screws or buttons or opening tight jars? |  |
| Have you ever had a neck, arm or hand injury or operation? |  |
| **If Yes, please provide details:** |
| Have you ever had any serious diseases of the joints, skin, nerves, heart or blood vessels? |  |
| **If Yes, please provide details:** |
| Are you on any long term medication? |  |
| **If Yes, please provide details:** |

**I certify that all the answers above are true to the best of my knowledge and belief and I give my explicit consent to Persimmon to process my special category personal data relating to my health.**

|  |  |
| --- | --- |
| **Signed** |  |
| **Date** |  |

## PLEASE RETURN THIS FORM TO: Healthscreening@Persimmonhomes.com

## Or alternatively post to – Group HS&E Administrator, Persimmon Plc, Persimmon House, Fulford, York, YO19 4FE

## Please mark as ‘private and confidential’

## Our legal basis for processing your personal information and our additional legal basis for processing the special category data relating to your health includes the following:

## Article 6(1)(c) GDPR – processing is necessary for Persimmon to comply with its legal obligations to provide safe working environment and ensure the health and safety of visitors to its premises;

## Article 6(1)(f) GDPR – processing is necessary for the purposes of the controller's legitimate interests;

## Article 9(2)(b) GDPR – processing of special category personal data is necessary for Persimmon to carry out obligations in the field of employment, social security and social protection law; and

## Article 9(2)(a) GDPR – processing of special category personal data is undertaken with the Data Subject’s explicit consent.

## The storage of personal data relating to health screening with be undertaken securely in accordance with our data protection policy and access to your records will be limited to relevant personnel within your operating business, HS&E Dept. and HR Dept.