

**HEALTH ASSESSMENT QUESTIONNAIRE FOR NIGHT WORKERS**

**Part 1 – Initial Questionnaire**

It is your right under the Working Time Regulations 1998 to have a health assessment before being assigned to night work and at regular intervals thereafter whilst a night worker. This questionnaire will be used to assess if you have any conditions which may affect your ability to do night work only.

Medical details provided are **confidential**. Your Manager/Supervisor will normally be advised of your fitness or unfitness to do night work only. However, where an employee is assessed as unfit to do night work it may be necessary to provide additional advice to management with your consent.

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**SECTION A:**

**Must be completed by Manager/Supervisor prior to issue to employee**

Please give a brief description of the type of work the employee is to be assigned to and any special hazards including physical/mental strain.

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**SECTION B: PERSONAL DETAILS**

NAME: ..... DoB: ...../...../.....

ADDRESS: .....

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HOME TEL NO: ..... MOBILE NO: .....

POST HELD: ..... WORKPLACE: .....

DATE COMMENCED CURRENT POST: ..... WORK TEL NO: .....

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**SECTION C: HEALTH QUESTIONNAIRE**

Please answer **all** questions by ticking the appropriate box. Please note that ticking “Yes” does not mean that you will not be fit for night work but a further assessment by a health professional may be required.

Where you have answered “Yes” please give further details overleaf including any diagnosis or condition, treatments/medication you take, is your condition well controlled, how long you have had it, and any problems it causes you etc.

		Yes	No
1a	Do you suffer from diabetes?		
1b	If ‘yes’ is it under control?		
1c	Does it require treatment with insulin injections on a strict timetable?		
2a	Do you suffer from any heart disease/problems or circulatory disorders ie angina, high blood pressure		
2b	If “yes” does this affect your physical stamina in any way?		
3	Do you suffer from any stomach or intestinal disorder ie ulcers, irritable bowel?		
4	Do you get frequent indigestion, heartburn or belching?		
5	Do you have any condition where the timing of meals is particularly important or on a special diet?		
6	Do you suffer from any medical condition affecting your sleep or sleep disorders?		
7a	Do you have asthma, bronchitis or any chronic chest disorder?		
7b	Is it well controlled?		
7c	Does your condition cause night-time symptoms that are particularly troublesome ie short of breath, wheezing, coughing bouts?		
8	Do you suffer from depression, “stress”, nervous disorders or other mental illnesses or had drug or alcohol addiction?		
9	Do you have any condition requiring regular medication at strict times, eg epilepsy, thyroid disease?		
10	Do you have any other health conditions/health problems that may affect your ability to do night work?		
11	Do you consider yourself to have a disability that may affect your ability to do your job?		
12	Are you currently receiving any treatment from your GP, osteopath, homeopath, chiropractor or any other health professional (please detail who and what treatment)?		
13	Do you currently take any medication which is prescribed by a doctor; bought over the counter; given to you by a herbalist; homeopath or other health professional (please detail who and what)?		
14a	Have you previously worked night duty?		
14b	When? ..... How long for? .....		

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**ADDITIONAL INFORMATION:**

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**SECTION D: SHIFT PATTERN**

What are your weekly hours of work? .....

What shift pattern do you normally work (including hours of work)? (Please detail or attach rota)

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How often would you be required to do night work?

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**SECTION E: DECLARATION**

I certify that the above information is correct to the best of my knowledge and belief.

I understand that the results of this Assessment will not be disclosed to any other person without my written consent, other than confirmation that I am fit to take up or continue to undertake night work or that I have been referred for further medical consultation.

Employee's Signature: ..... Date: .....

Please return completed form to:

.....

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**SECTION F: EMPLOYER'S ASSESSMENT**

After reviewing the above questionnaire, my assessment is that that this employee –

can work nights

cannot work nights

should see a doctor or nurse for a medical examination to assess whether they can work nights

Full Name: ..... Job Title: .....

Signature: ..... Date: .....

*Completed form to be retained on employee's Personal File (and copy provided to employee)*

**HEALTH ASSESSMENT QUESTIONNAIRE FOR NIGHT WORKERS**

**Part 2 – Review Questionnaire**

Under the Working Time Regulations 1998 you have the right to regular health assessments whilst a night worker. **You will have previously completed a Health Assessment Night Worker Questionnaire.** This questionnaire will be used to review if you have, or have developed since your previous assessment, any conditions which may affect your ability to do night work. Medical details provided are **confidential**.

Your Manager/Supervisor will normally be advised of your fitness or unfitness to do night work only. However, where an employee is assessed as unfit to do night work it may be necessary to provide additional advice to management.

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**SECTION A:**

**Must be completed by Manager/Supervisor prior to issue to employee**

Please give a brief description of the type of work the employee is currently/to be assigned to and any special hazards including physical/mental strain.

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**SECTION B: PERSONAL DETAILS**

NAME: ..... DoB: ...../...../.....

ADDRESS: .....

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HOME TEL NO: ..... MOBILE NO: .....

POST HELD: ..... WORKPLACE: .....

DATE COMMENCED CURRENT POST: ..... WORK TEL NO: .....

When did you last complete a Night Workers questionnaire? (Year): .....

Was a further assessment by a health professional required? (Yes/No): .....

**SECTION C : HEALTH QUESTIONNAIRE**

Please answer **all** questions by ticking the appropriate box. Please note that ticking “Yes” does not mean that you will not be fit for night work but a further assessment by a health professional may be required.

Where you have answered “Yes” please give further details overleaf including any diagnosis or condition, treatments/medication you take, whether your condition is well controlled, how long you have had it, and any problems it causes you etc.

		Yes	No
1	Have you had any sickness absence from work since you last completed a Night Workers questionnaire? (If yes, please detail number of days; number of occasions and the reasons for absence.)		
2	Have you developed any health problems/conditions since you last completed a Night Workers questionnaire?		
3	Do you currently suffer from:		
3a	Diabetes		
3b	Sleep disorders		
3c	Heart disease of any sort, including raised blood pressure		
3d	Chest disorders		
3e	Stomach/intestinal disorders		
3f	Nervous/mental disorders/anxiety/depression/alcohol or substance abuse		
3g	Any condition requiring regular medication at strict times		
3h	Epilepsy/fainting fits		
3i	Any other current health problem/condition? (If yes, detail)		
4	Do you currently take any medication which is prescribed by a doctor; bought over the counter; given to you by a herbalist; homeopath or other health professional? (If yes, please detail who and what.)		
5	Are you currently receiving any treatment from your GP, osteopath, homeopath, chiropractor or any other health professional (please detail who and what treatment)?		
6	Have you a disability that may affect your ability to do your job?		
7	Are you aware of any other health factors that may affect your fitness to do night work?		

**ADDITIONAL DETAILS**

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**SECTION D: SHIFT PATTERN**

- 1 What hours do you work? .....
- 2 Do you work permanent nights or on a shift pattern? .....
- 3 What shift pattern do you normally work? (Please detail or attach rota)  
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**SECTION E: DECLARATION**

I certify that the above information is correct to the best of my knowledge and belief.

I understand that the results of this Assessment will not be disclosed to any other person without my written consent, other than confirmation that I am fit to take up or continue to undertake night work or that I have been referred for further medical consultation.

Employee's Signature: ..... Date: .....

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Please return completed form to:

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**SECTION F: EMPLOYER'S ASSESSMENT**

After reviewing the above questionnaire, my assessment is that that this employee –

- can work nights
- cannot work nights
- should see a doctor or nurse for a medical examination to assess whether they can work nights

Full Name: ..... Job Title: .....

Signature: ..... Date: .....

*Completed form to be retained on employee's Personal File (and copy provided to employee)*

**Part 3 – DECLARATION OF EMPLOYEES DECLINE OF NIGHT WORKER’S HEALTH ASSESSMENT**

**SECTION A:** (Manager/Supervisor to complete)

I (Insert full name) ..... have informed

(insert full name) .....  
of his/her rights under the Working Time Regulations 1998 and of his/her right to free health assessments.

Full Name: ..... Job Title: .....

Signature: ..... Date: .....

**SECTION B:** (Employee to complete)

I have had my rights explained to me but wish to decline the offer of a free night worker’s health assessment.

Full Name: ..... Job Title: .....

Signature: ..... Date: .....

*Completed form to be retained on employee’s Personal File (and copy provided to employee)*