



## Shell Health Services Appendix D Form Q1 Health Status Questionnaire

Please answer the questions by ticking the correct box. If you are not sure, leave the question blank and ask your health advisor what it means. Your health advisor may ask you additional questions during the examination.

Employee Data		Date	
Last Name		First Name	
I.D No.	Tel #	Occupation	
		No	Yes
1. Are you currently being treated by a doctor for any illness or injury? If yes please briefly describe		<input type="radio"/>	<input type="radio"/>
2. Are you receiving any medical treatment or taking any medication (either prescribed or otherwise)? If yes please list		<input type="radio"/>	<input type="radio"/>
3. Have you ever had, or been told by a doctor that you had any of the following?		No	Yes
3.1 High blood pressure		<input type="radio"/>	<input type="radio"/>
3.2 Heart disease		<input type="radio"/>	<input type="radio"/>
3.3 Chest pain, angina		<input type="radio"/>	<input type="radio"/>
3.4 Any condition requiring heart surgery		<input type="radio"/>	<input type="radio"/>
3.5 Palpitations/irregular heartbeat		<input type="radio"/>	<input type="radio"/>
3.6 Abnormal shortness of breath		<input type="radio"/>	<input type="radio"/>
3.7 Head injury, spinal injury		<input type="radio"/>	<input type="radio"/>
3.8 Seizures, fits, convulsions, epilepsy		<input type="radio"/>	<input type="radio"/>
3.9 Blackouts, fainting		<input type="radio"/>	<input type="radio"/>
3.10 Stroke		<input type="radio"/>	<input type="radio"/>
3.11 Dizziness, vertigo, problems with balance		<input type="radio"/>	<input type="radio"/>
3.12 Double vision, difficulty seeing		<input type="radio"/>	<input type="radio"/>
3.13 Colour blindness		<input type="radio"/>	<input type="radio"/>
3.14 Kidney disease		<input type="radio"/>	<input type="radio"/>
3.15 Diabetes		<input type="radio"/>	<input type="radio"/>
3.16 Neck, back or limb disorders		<input type="radio"/>	<input type="radio"/>
3.17 Hearing loss or deafness or had an ear operation or use a hearing aid		<input type="radio"/>	<input type="radio"/>
3.18 Do you have difficulty hearing people on the telephone (including use of hearing aid if worn)?		<input type="radio"/>	<input type="radio"/>

## Form Q1 Continued

3.19 Have you ever had, or been told by a doctor that you had a psychiatric illness, or nervous disorder?	<input type="radio"/>	<input type="radio"/>
3.20 Have you ever had any other serious injury, illness, operation, or been in hospital for any reason?	<input type="radio"/>	<input type="radio"/>
4.1 Have you ever had, or been told by a doctor that you had a sleep disorder, sleep apnoea, or narcolepsy?	<input type="radio"/>	<input type="radio"/>
4.2 Has anyone noticed that your breathing stops or is disrupted by episodes of choking during your sleep?	<input type="radio"/>	<input type="radio"/>
5.1 When was the last time you had more than 4 drinks (female) or 5 drinks (male) in 1 day in the past 3 months <input type="radio"/> last 7 days <input type="radio"/> last 4 weeks <input type="radio"/> last 3 months <input type="radio"/> not in the last 3 months		
5.2 Has a relative or friend or a doctor or other health worker been concerned about your drinking or suggested you cut down? <input type="radio"/> No <input type="radio"/> Yes, but not in the last year <input type="radio"/> Yes, during the last year		
	<b>No</b>	<b>Yes</b>
6. Do you use illicit drugs?	<input type="radio"/>	<input type="radio"/>
6.1 Have you ever been treated for alcohol or substance abuse	<input type="radio"/>	<input type="radio"/>
7. Do you use any drugs or medications not prescribed for you by a doctor?  <b>If yes list here.</b>	<input type="radio"/>	<input type="radio"/>
8. Have you been in a vehicle crash since your last license examination? ( Drivers only)  <b>If Yes, please give details:</b>	<input type="radio"/>	<input type="radio"/>

**Declaration:** I, \_\_\_\_\_ (Print Name) certify that to the best of my knowledge the above information supplied by me is true and correct.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

### Office use only

**Health advisor's comments**

<b>Date</b>	<b>Signature</b>	<b>Print Name</b>

**Acknowledgement: Adapted from Australian Driving Standards**