



About Your Work and Your Health and Wellbeing

Your answers to these questions will help your healthcare provider understand the possible effect of your current or previous work on your health/wellbeing and of your health on your ability to do your work.

Name: _____ Date of Birth (YYYY/MM/DD): _____

1. What is your current employment status? (*Check and then circle most appropriate answer*)
 - Employed by an organization full-time / part-time / on leave (*Go to question 3*)
 - Self-employed full-time / part-time / on leave (*Go to question 3*)
 - Full-time university or college student / Homemaker / Not employed / Long term disability benefits/ Retired (*Go to Question 2*)
2. If not currently employed, when was your last approximate date worked and how long did you work at that job? Last date worked YYYY/MMM ____ / ____

How long were you employed in your last job _____ Years _____ Months (*Go to question 4*)
3. How long have you been at your current job? _____ Years _____ Months
4. For your current or last job worked, what was your occupation/job title? (*Please give your full job title and be specific. For example: Fruit picker, Legal secretary, Restaurant manager, Secondary school teacher, Dry waller, Heavy Equipment Mechanic ...*)

5. For your current or last job worked, what are/were your main tasks or duties in the job? (*Please give details, for example: picking and carrying apples and peaches, preparing legal documents, managing the operations of a restaurant and serving customers, teaching mathematics, taping and sanding walls, grinding and using impact wrenches...*)

6. Do / did you work in more than one job at the same time? Yes / No

Details _____
7. Which one of the following **best describes** your working schedule in your **current main job** (or last job worked)?
A night shift is work during the early hours of the morning, after midnight. An evening shift is work during the evening ending at or before midnight. Check ONE only:
 - Regular daytime schedule or shift
 - Regular evening shift
 - Regular night shift
 - Irregular schedule, or on call
 - Rotating shift, changing periodically from days to evenings or to nights
 - Split shift, consisting of two or more distinct periods each day
 - Other, please specify _____
8. Are there any hazardous exposures (*toxic chemicals, dusts such as silica or asbestos, blood or infectious agents, noise, vibration, radiation, temperature extremes, lifting, awkward postures, work at heights, stressful work, bullying, violence etc.*) that you are worried about in your current job or for your previous jobs? Yes / No

What concerns you and why? _____

9. Do you have to use any personal protective equipment at work? (For example: respirator / breathing mask, gloves, ear plugs or defenders, other special items) Yes / No
What items and why? _____

10. Do you have or have you had a medical condition caused or made worse by work? Yes/ No
Please name the condition and what you believe was the workplace cause:

11. Do any of your co-workers that do or did the same job or work you have previously done, develop medical conditions that were caused or made worse by the job? Yes / No

Details: _____

12. Current work ability (*how well you can do your job*) compared to highest work ability ever: Assume that your work ability at its best has a value of 10 points. How many points would you give your current work ability? (*Circle the most appropriate answer*)
(0 means that you currently cannot work at all) (10 work ability at its best)

0 1 2 3 4 5 6 7 8 9 10

13. Are you satisfied with your current job? Y/N

Details: _____

14. If you were employed in other jobs before your current job/last job worked, please provide the approximate dates of employment, job title, and job duties for each of these jobs:

Dates of Employment	Job Title	Job Duties Description

Office Use: Questionnaire completed Intake Regular Appointment Periodic Health Exam Other _____

self-completed interviewer completed

Provider role: Nurse Practitioner Nurse Physician Other _____