Sample Forms

Sample Form: Confidential Personal Wellness Assessment

This is a confidential document and is intended to be completed privately and shared with your health care provider ONLY.

You may self-describe potential workplace health exposures to provide your health care professional with an overview of factors that may be impacting your health. All questions are based on your activities over the past 12 months.

Name _____ Age _____ Date _____

Percentage of work time on the farm _____% Off the farm _____%

Type of off-farm work _____

When working off-farm, I am/was exposed to:	Yes	No
Chemicals		
Loud noise		
Heavy lifting		
Dusts (specify)		
Other substances (specify)		

When working on-farm, I work with the following crops and livestock:

_____

Chemicals handled:	Yes	No
Anhydrous ammonia		
Fertilizer –		
Liquid		
Granular		

	Yes	No
Pesticides:		
Insecticides		
Herbicides		
Fungicides		
Fumigants		
Other (specify)		

Personal Protective Equipment worn when working with chemicals:	Always	Sometimes	Never
Eye protection			
Chemical resistant gloves			
Chemical resistant boots			
Disposable/chemical resistant coveralls			

Chemical handling practices	Always	Sometimes	Never
Wear clean clothes every day			
Immediately change clothes if contaminated			
Wash contaminated clothing separate from family laundry			
Wash face and hands before eating			
Wash hands before urinating			

Noise exposure:	Yes	No
Work with power tools, machinery, animals		
Do recreational activities, hunt, music, ATVs		
Work off-farm in a noisy environment		
Do you experience:		
Ringing in the ears		
Dizziness		
Difficulty understanding conversation with background noise		

Do you wear **respiratory protection**?

What type? _____

After working where there was dust, fumes, vapours, did you experience:	Never	Occasionally	Constantly
Dry cough			
Chest tightness			
Cough with phlegm			
Throat irritation			
Wheezing chest			
Sinus problems			
Stuffy nose			
Ear popping			

When are any of these symptoms worst? _____

Skin	Yes	No
Do you have any skin spots that have changed in size, colour, shape or thickness		
Areas of skin that bleed or do not heal		
Mouth sores or irritation		

Bones and Joints – Do you have any aches, pain or discomfort in your:	Yes	No
Neck		
Shoulder		
Upper back		
Elbow		
Lower back		
Wrist/hand		
Hip/knee		
Feet		

Medications List any prescription or over-the-counter medications you currently take daily or when needed	
Name of Medication	Reason for Use and How Often

Family history Do you or any family members (parents, siblings, children) have a history of:	You	Family Member		Relationship		
		Yes	No	Parent	Child	Sibling
Asthma						
Emphysema						
Hay fever						

Family history Do you or any family members (parents, siblings, children) have a history of:	You	Family Member		Relationship		
		Yes	No	Parent	Child	Sibling
Allergies						
Heart disease						
High blood pressure						
Stroke						
Diabetes						
Kidney disease						
Liver disease						
Cancer (specify)						
Arthritis						
Other (specify)						

Your health record – When did you last receive the following health services:	Past year	1-3 years ago	More than 3 years ago	Never
Routine check-up/physical				
Blood pressure check				
Cholesterol check				
Colorectal exam				
Eye exam				
Dental exam				
Diabetes screening				
Flu shot				
Prostate exam (men only)				

	Past year	1-3 years ago	More than 3 years ago	Never
Mammogram (women only)				
Pap smear (women only)				

Stress – Have you had any of the following in the past year:	Yes	No
Poor appetite		
Feelings of extreme loneliness		
Blame yourself for things		
Feeling hopeless about the future		
Worry too much about things		

Questions or issues to ask your health care provider:

_____

_____

_____

_____

_____