Lusail Real Estate Development Company

Health, Safety, Security, Environment, Logistics & Quality Department

Lusail Construction Safety Procedural Forms/Checklists – Employee Health Assessment & Historic Health Exposure

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COMPANY PROPRIETARY INFORMATION

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Amendment Record

This document is reviewed to ensure its continuing relevance to the systems and process that it describes. A record of contextual additions or omissions is given below:

Rev. No	Description / Comments	Prepared By	Checked By	Approved By	Issue Date
1	(Pg. 1) Company Propriety Information – Not controlled if printed has been added.	HSE Working Group	Michael Ford	Uwe Krueger	1st April 2015
1	(Pg. 2) Revised Amendment Table	HSE Working Group	Michael Ford Michael Ford	Uwe Krueger	1st April 2015

LUSAIL

Medical History

Please complete this document, print and sign. Return hard copy to Health Advisor. This document is a confidential document.

Part A. Employee or Applicant: Please complete Parts A through L prior to exam.

F.I. M.I. Last Name Called Name	Birth Date (MM-DD-YY)	☐ Male ☐ Female	Employee Number:
Job Title	Company		Work Location
Home Address City	State Code		Date (MM-DD-YYYY)

Part B. General Health

1. Compared to other people your age and sex, how would you rate your overall health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

If poor, state reason: ____________________

2. In general, how satisfied are you with the way you spend your time (at work and at home)?

☐ Very ☐ Somewhat
☐ Generally pretty satisfied ☐ Not satisfied

3. Do you have any physical/medical limitations that would restrict you from participating in activities that you would like to do?

☐ No
☐ Yes → What is this limitation? ____________________

4. Are you on a special diet of any kind? ☐ No ☐ Yes

If yes, explain ____________________

Part C. Exercise

Do you exercise routinely?

☐ No
☐ Yes → Is your exercise program one that you engage in at least 3 times per week and that causes you to breathe hard for at least twenty minutes each time?
☐ No ☐ Yes

Part D. Family History

1. Has any blood relative been diagnosed as having, or died of any of the following conditions? (other blood relative = grandparent, brother, sister, aunt, uncle, first cousin)

☐ No ☐ Yes → Specify below:

Condition	Mother	Father	Other Blood Relative
Diabetes	☐	☐	☐
Asthma	☐	☐	☐
Stroke	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Heart Disease	☐	☐	☐
Anemia/Other Blood Disorders	☐	☐	☐
Cancer (specify type)	☐	☐	☐

Part E. Medications

1. In the *past 12 months* have you taken any of the following medications? If yes, please provide the additional information.

Medication Type	No / Yes	Medication Name	Reason	Currently Taking It? No / Yes
Allergy or Asthma Medication	☐ ☐			☐ ☐
Anticoagulants	☐ ☐			☐ ☐
Aspirin or Aspirin Containing Tablets	☐ ☐			☐ ☐
Birth Control Pills	☐ ☐			☐ ☐
Female Hormones	☐ ☐			☐ ☐
Blood Pressure Medications	☐ ☐			☐ ☐
Iron Pills	☐ ☐			☐ ☐
Oral Diabetes Medicine	☐ ☐			☐ ☐
Tranquilizer/Sedative	☐ ☐			☐ ☐
Sleeping Pills	☐ ☐			☐ ☐
Antibiotics	☐ ☐			☐ ☐
Other Medications (prescription and non-prescription)	☐ ☐			☐ ☐

2. Are you allergic to any medications? ☐ ☐

If yes, what medications? ______________________________

Part F. Exposure History

Have you regularly been exposed to any of the following *for at least 6 months*? If yes, check all boxes that apply.

Exposure	No / Yes		How Long? (# of Yrs.)	Exposed at Work	Use In A Hobby	Respirator Or Protective Clothing Usually Worn	Currently Exposed
Dusts/Fumes							
Asbestos	☐	☐	______	☐	☐	☐	☐
Asphalt Fumes	☐	☐	______	☐	☐	☐	☐
Arsenic	☐	☐	______	☐	☐	☐	☐
Cement Dust	☐	☐	______	☐	☐	☐	☐
Lead, Lead Compounds	☐	☐	______	☐	☐	☐	☐
Insulation Materials	☐	☐	______	☐	☐	☐	☐
Mineral Dusts	☐	☐	______	☐	☐	☐	☐
Silica Dusts	☐	☐	______	☐	☐	☐	☐
Welding, Soldering Fumes	☐	☐	______	☐	☐	☐	☐
Wood Dusts	☐	☐	______	☐	☐	☐	☐
Other Dusts and Fumes	☐	☐	______	☐	☐	☐	☐
If yes, specify: ______							
Chemical Agents							
Benzene	☐	☐	______	☐	☐	☐	☐
Cutting Oil	☐	☐	______	☐	☐	☐	☐
Degreasers	☐	☐	______	☐	☐	☐	☐
Dyes	☐	☐	______	☐	☐	☐	☐
Epoxies	☐	☐	______	☐	☐	☐	☐
Formaldehyde	☐	☐	______	☐	☐	☐	☐
Paint Remover	☐	☐	______	☐	☐	☐	☐
Solvents, Cleaning Fluids	☐	☐	______	☐	☐	☐	☐
Other Vapors, e.g. Gasoline	☐	☐	______	☐	☐	☐	☐
If yes, specify: ______							
Other Agents							
Adhesives, Rubber Cement	☐	☐	______	☐	☐	☐	☐
Engine Exhaust	☐	☐	______	☐	☐	☐	☐
Hot Roofing Materials	☐	☐	______	☐	☐	☐	☐
Lacquer, Paint, Stains	☐	☐	______	☐	☐	☐	☐

Pesticides	☐	☐	________	☐	☐	☐	☐
Resins, Plastics	☐	☐	________	☐	☐	☐	☐
Physical Factors							
Noise	☐	☐	________	☐	☐	☐	☐
Radiation/X-ray Equipment	☐	☐	________	☐	☐	☐	☐
Vibrating Hand Tools	☐	☐	________	☐	☐	☐	☐
Wrist, Hand Repetitive Motion	☐	☐	________	☐	☐	☐	☐

Part G. Occupational History

Have you worked *at least six months* in a:

	No	Yes	From (Year)	To (Year)
Chemical Plant	☐	☐	______	______
Cotton, Flax or Hemp Mill	☐	☐	______	______
Electronics Plant	☐	☐	______	______
Fertilizer Plant	☐	☐	______	______
Foundry	☐	☐	______	______
Grain Silo or Elevator	☐	☐	______	______
Imitation Leather Plant	☐	☐	______	______
Mine	☐	☐	______	______
Pesticide Plant	☐	☐	______	______
Pharmaceutical Plant	☐	☐	______	______
Plastics Plant	☐	☐	______	______
Pottery	☐	☐	______	______
Print Shop	☐	☐	______	______
Quarry	☐	☐	______	______
Rubber Process Plant	☐	☐	______	______
Service Station/Garage	☐	☐	______	______
Shipyard/Tanker Crew	☐	☐	______	______
Shoe/Leather Factory	☐	☐	______	______
Smelter	☐	☐	______	______

Have you worked *at least six months* as a(n):

			From (Year)	To (Year)
Abrasive Blaster	☐	☐	______	______
Insulator	☐	☐		

Part H. Tobacco Use

1. Cigarette Smoking

Have you ever smoked cigarettes?

☐ No ☐ Yes

↙ If no, skip to 2.

If yes, at what age did you start? ____________

Do you smoke cigarettes now? ☐ No ☐ Yes

If no, at what age did you last quit? ____________

On the average, how many cigarettes *a day* do you or did you smoke?

(check [ ] one.)

☐ Less Than 1 Cigarette Per Day
☐ 1 - 9 Cigarettes Daily (Less than 1/2 Pack)
☐ 10 - 20 Cigarettes Daily (1/2 - 1 Pack)
☐ 21 - 40 Cigarettes Daily (1 - 2 Packs)
☐ More Than 40 Cigarettes Daily (Over 2 Packs)

2. Cigar/ Pipe Smoking

Have you ever smoked more than 1 cigar per week for a year?

☐ No ☐ Yes

↙ If no, skip to 3.

At what age did you start? ____________

On the average, how many cigars a day do you or did you smoke? ____________

If you have quit, at what age did you last quit? ____________

3. Shisha Smoking

Have you ever smoked shisha regularly?

☐ No ☐ Yes

Painter	☐	☐	_______	_______
Welder	☐	☐	_______	_______

↙ If no, skip to 4.

At what age did you start? ___________

About how many head of shisha a day do you or did you smoke? ___________

If you have quit, at what age did you last quit? ___________

4. If you smoke (d), did you or do you inhale the smoke?

	Not At All	Slightly	Moderately	Deeply
Cigarettes	☐	☐	☐	☐
Cigars	☐	☐	☐	☐
Shisha	☐	☐	☐	☐

5. Did you ever chew tobacco regularly for *at least six months*?

☐ No ☐ Yes

Part I. Alcohol Consumption

1. Do you currently drink alcoholic beverages? ☐ No ☐ Yes

If no, did you drink alcoholic beverages in the past?

☐ No → Skip to **Section H, Tobacco Use**

☐ Yes → What age did you last stop? ___________

2. What is/was your approximate *weekly* intake of the following alcoholic beverages (if < 1 put 0):

Beer ________ # Bottles or Cans Per Week

Wine ________ # Glasses Per Week

Liquor ________ # Straight or Mixed Drinks Per Week

Part J. Please read this section carefully and answer each item to the best of your knowledge. This information is being collected in the interest of your personal health and safety.

Describe each "YES" answer in Part K.

HAVE YOU EVER HAD, OR DO YOU NOW HAVE:	No	Yes		No	Yes		No	Yes
1. FREQUENT OR SEVERE HEADACHES	☐	☐	28. SWELLING OF LEGS	☐	☐	54. FREQUENT OR PAINFUL URINATION	☐	☐
2. HEAD INJURIES	☐	☐	29. PALPITATION OR POUNDING HEART	☐	☐	55. BLOOD IN URINE	☐	☐
3. LOSS OF CONSCIOUSNESS	☐	☐	30. HIGH BLOOD PRESSURE	☐	☐	56. ARTHRITIS, GOUT OR RHEUMATISM	☐	☐
4. DIZZINESS OR FAINTING SPELLS	☐	☐	31. TREATMENT FOR HIGH BLOOD PRESSURE	☐	☐	57. BROKEN BONES, DISLOCATIONS, AMPUTATIONS OR SPRAINS	☐	☐
5. EPILEPSY (SEIZURE DISORDER)	☐	☐	32. HEART TROUBLE	☐	☐	58. ANY TYPE OF BONE OR JOINT TROUBLE	☐	☐
6. EYE TROUBLE	☐	☐	33. HEART MURMUR/RHEUMATIC FEVER	☐	☐	59. BACK OR NECK TROUBLE	☐	☐
7. PERFORATED EARDRUMS OR DRAINING EARS	☐	☐	34. A STROKE	☐	☐	60. CHIROPRACTIC TREATMENT	☐	☐
8. RINGING IN EITHER EAR	☐	☐	35. EXCESSIVE BLEEDING PROBLEMS	☐	☐	61. WORN A BRACE OR SUPPORT	☐	☐
9. HEARING LOSS	☐	☐	36. ANEMIA OR OTHER BLOOD CONDITION/BLOOD TRANSFUSION	☐	☐	62. PARALYSIS, MUSCLE OR NERVE PROBLEM	☐	☐
10. SINUS INFECTIONS	☐	☐	37. VARICOSE VEIN TROUBLE	☐	☐	63. NUMBNESS, TINGLING, TREMORS OR TWITCHING	☐	☐
11. HAY FEVER	☐	☐	38. HEMORRHOIDS OR RECTAL BLEEDING	☐	☐	64. RASH OR SKIN DISEASE	☐	☐
12. ANY OTHER ALLERGIES	☐	☐	39. FREQUENT NAUSEA, VOMITING OR INDIGESTION	☐	☐	65. NON-CHILDHOOD IMMUNIZATIONS OR INJECTIONS	☐	☐
13. PERSISTENT HOARSENESS	☐	☐	40. UNEXPLAINED WEIGHT LOSS OR GAIN	☐	☐	66. REACTION/ALLERGY TO ANY INJECTIONS OR MEDICINE	☐	☐
14. MOUTH/DENTAL PROBLEMS	☐	☐	41. GALL BLADDER OR PANCREAS TROUBLE	☐	☐	67. TUMOR, GROWTH, CYST OR CANCER	☐	☐
15. OTHER EAR, NOSE, OR THROAT TROUBLE	☐	☐	42. ULCER OR HEARTBURN	☐	☐	68. EMOTIONAL PROBLEM	☐	☐

Item	☐	☐	Item	☐	☐	Item	☐	☐
16. ASTHMA	☐	☐	43. HEPATITIS OR JAUNDICE	☐	☐	69. MENTAL ILLNESS OR TREATMENT	☐	☐
17. EMPHYSEMA/CHRONIC BRONCHITIS	☐	☐	44. CHRONIC CONSTIPATION AND/OR DIARRHEA	☐	☐	70. USED MARIJUANA, COCAINE OR OTHER "STREET DRUGS"	☐	☐
18. CHRONIC COUGH	☐	☐	45. BLACK OR TARRY STOOL	☐	☐	71. DATE OF LAST CHEST X-RAY (MM/YY)	________	
19. FREQUENT COLDS	☐	☐	46. OTHER STOMACH, INTESTINAL, OR LIVER TROUBLE	☐	☐	72. IF YOU HAVE EVER WORN A RESPIRATOR, DID IT CAUSE ANY PROBLEMS?	☐	☐
20. COUGHED OR SPIT UP BLOOD	☐	☐	47. HERNIA OF ANY TYPE	☐	☐	73. HAVE PAST OR PRESENT DISABILITY CLAIM (AND/OR CONDITION)	☐	☐
21. TUBERCULOSIS/POSITIVE TB SKIN TEST	☐	☐	48. GOITER, THYROID, OR PITUITARY TROUBLE	☐	☐	74. DO YOU HAVE ANY BIRTH ABNORMALITY (CONGENITAL)	☐	☐
22. PNEUMONIA	☐	☐	49. LUMPS OR ENLARGED GLANDS	☐	☐	75. FOR WOMEN ONLY		
23. SHORTNESS OF BREATH WHEN NOT EXERCISING	☐	☐	50. DIABETES OR ABNORMAL BLOOD SUGAR	☐	☐	A. ANY DISCHARGE, LUMPS, OR PAIN IN BREASTS	☐	☐
24. EXCESSIVE FATIGUE WITH WORK OR EXERCISE	☐	☐	IF YES, TAKING INSULIN?	☐	☐	B. CURRENTLY INCAPABLE OF HAVING CHILDREN	☐	☐
25. PAIN OR PRESSURE IN CHEST	☐	☐	51. AIDS, OR AIDS RELATED ILLNESS	☐	☐	C. ARE YOU PREGNANT NOW?	☐	☐
26. PNEUMOTHORAX/COLLAPSED LUNG	☐	☐	52. SEXUALLY TRANSMITTED DISEASE ("VD")	☐	☐	D. MISSED LAST MENSTRUAL PERIOD?	☐	☐
27. ANY OTHER CHEST OR LUNG TROUBLE	☐	☐	53. URINARY BLADDER/PROSTATE/ KIDNEY PROBLEMS	☐	☐	E. DATE OF LAST PERIOD (MM/DD/YY)	________	

Do you have any other health problems you'd like to discuss with the physician? ☐ **No** ☐ **Yes** ⌫ **describe on page 8**

EMPLOYEE/APPLICANT:

I certify that the information given by me is true and I authorize the examiner to furnish the results of this examination to the Lusail Occupational Health Advisor

I understand that any misrepresentation, false statement or omission herein may result in the company rejecting my application, withdrawing any offer of employment, or terminating my employment at any time.

Employee Signature ______________________________ Date (DD/MM/YYYY) ______________

Part K. Applicant/Employee: Fully describe each "yes" answer from page 6.

	Diagnosed By Physician	Have You Experienced This *Within The Past 12 Months?*
# : ___ Description: ______	☐ N ☐ Y	☐ N ☐ Y
# : Description: ______	☐ N ☐ Y	☐ N ☐ Y
# : Description: ______	☐ N ☐ Y	☐ N ☐ Y
# : Description: ______	☐ N ☐ Y	☐ N ☐ Y
# : Description: ______	☐ N ☐ Y	☐ N ☐ Y
# : Description: ______	☐ N ☐ Y	☐ N ☐ Y
# : Description: ______	☐ N ☐ Y	☐ N ☐ Y
# : Description: ______	☐ N ☐ Y	☐ N ☐ Y
# : Description: ______	☐ N ☐ Y	☐ N ☐ Y

Please list any surgery and/or hospitalizations you have had.

Date	Type of Surgery/Reason For Hospitalization	Completely Resolved
		☐ N ☐ Y
		☐ N ☐ Y
		☐ N ☐ Y
		☐ N ☐ Y

If you have any other health problems you would like to discuss with the physician, please list them here.

Employee Name	

Part M. Report of Physical Examination. To be completed by physician, physician's assistant, or nurse practitioner.

Height	cm	
Weight	kg	
Blood Pressure	R	L
Pulse Rate		Regular?
Urine (Reag.Strip)	Sugar pH	Protein SP.GR.
Audiogram Performed?	☐ No	☐ Yes
If no, examiner's impression of hearing ability	☐ Normal	☐ Abnormal

	No	Yes
Color Blindness	☐	☐
Red/Green Defect?		☐
Other Color Defect?		☐

Depth %
Perimeter Score Rt. Lt.

Vision	Uncorrected			Corrected ☐ Glasses ☐ Contacts		
	Both	Right	Left	Both	Right	Left
Far	20/	20/	20/	20/	20/	20/
Near	J#	J#	J#	J#	J#	J#

Grip: Check Dominant Hand

☐ R ________ ________ ________ ☐ L ________ ________ ________ Instrument ____________ Setting ________

Forward Bending Knees Extended (distance fingertips from floor) ________ cm

Reflexes : Romberg ________ Patellar ________ Achilles ________

Pap Smear ________ ECG Treadmill ________ Mammogram ________ Sigmoidoscopy ________ X-Ray ________

Declined Declined Declined Declined Declined

	ABN	NORM		ABN	NORM		ABN	NORM
Head and Face			Heart			Upper Extremities (strength, range of motion)		
Eyes			Vascular System			Lower Extremities (strength, range of motion)		
Pupillary Reflex			Chest & Lungs (include breasts)			Spine (curvature, range of motion)		
Ears, Ear Drums			Abdomen & Viscera			Other Musculoskeletal		
Nose			Hernia (Rings)			Skin & Lymphatic		
Throat			Genitalia - Pelvic Exam			Deep Knee Bend		
Mouth			Anal Inspection			Sigmoidoscopy ______ CM Findings ______		
Neck-Thyroid			Rectal on Men Over 40 Years of Age					

REMARKS: (Describe/discuss significant findings and history; precede each entry with appropriate item number)

____
____
____
____
____

Summarize Significant Findings/Diagnosis (Suitable for ICD coding)

____
____
____
____
____

If any abnormalities were found during the examination, was applicant/employee informed: ☐ **No** ☐ **Yes**

Work Limitations
Medical Classifications

- ☐ A. No work limitations required
- ☐ B. Work limitations required
- ☐ C. Medical classification deferred

Physical Limitations

- ☐ Must wear contact lenses
- ☐ Other (describe)
- ☐ Must wear corrective lenses (glasses)

For Official use:

Date received:

Occupational Health Practitioner Comments and Follow-up requirement:

Data captured: ☐ N ☐ Y

Health education needed: ☐ N ☐ Y

Medical Clearance fit to work required: ☐ N ☐ Y