Occupational health screening

G 37 COMPUTER WORKPLACES

ArbMedVV (Occupational Health Screening Ordinance) Section 5, Annex Part 4, Para. 2

TÜVRheinland®
Genau. Richtig.

Please only complete the first page and bring the sheet with you to the examination.
You have today taken up your employer's offer of taking part in occupational health screening. Your employer is thus fulfilling its legal obligation to offer care.
Your information is voluntary, and is naturally subject to doctor-patient confidentiality.

Name:		**Company:**	
First name:		**Activity:**	
Date of birth:		**business phone:**	
Postcode town/city:		**How many hours per week do you work at the computer on average?**	**h**
Street, no.:			
private phone:			

Do you use a visual aid?

No ☐ yes ☐ ☐ Reading glasses ☐ Glasses ☐ Contact lenses
☐ Multifocal lens (split) ☐ Varifocals ☐ Other: _____

Glasses last adjusted: _____

Do you wear glasses when working on the computer?

No ☐ yes ☐ Which type? _____

Do you have special computer glasses?

No ☐ yes ☐ Which type? _____

How tall are you?	_____ cm	
Viewing distance eyes - surface of screen:	_____ cm	
What do you work with?	☐ PC ☐ Laptop ☐ Flatscreen	
What is the diagonal size of your screen in inches?	_____	inches
Do you have an eye disease (e.g., cataracts or glaucoma)?	☐ yes	☐ no
Have you ever had an eye operation?	☐ yes	☐ no
Is your close-up vision blurred despite glasses?	☐ yes	☐ no
Is your distance vision blurred despite glasses?	☐ yes	☐ no
Do suffer from any of the following?		
Headaches	☐ yes	☐ no
Shoulder/neck pain	☐ yes	☐ no
Back pain	☐ yes	☐ no
Eye problems	☐ yes	☐ no
Problems with your hands, wrists, arms?	☐ yes	☐ no
Do you see a connection between these complaints and your computer work? Which? (Please tick as appropriate)		
☐ Headaches ☐ Back pain ☐ Eyes stinging		
☐ Shoulder/neck problems ☐ Watery eyes ☐ Red eyes		
☐ Hands, wrists, arms ☐ Eye inflammation ☐ Flickering vision		
Are you being treated for high blood pressure?	☐ yes	☐ no
Are you a diabetic?	☐ yes	☐ no
Do regularly take medication?	☐ yes	☐ no
Do you exercise regularly (motion compensation)?	☐ yes	☐ no
Do you have any other problems at your computer workplace?	☐ yes	☐ no

More health complaints in activities on computer workplaces:

I confirm the correctness of my disclosures:

Date: _____ Signature: _____

Many thanks for your cooperation.

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Name: **First name:** **Date of birth:**

Visual acuity	Without glasses			With glasses		
	Right	Left	Both eyes	Right	Left	Both eyes
Dis-tance						
Clo-se-up						
Clo-se-up 50/70						

Stereo			
Phoria			
Fusion			
Colours			
Field of Vision		Amsler grid	

Device: _____ Assistant: _____

Findings

Eye position negative ☐ yes ☐ no

Head mobility negative ☐ yes ☐ no

Tension (shoulder) ☐ yes ☐ no

Other findings:

Result

glasses are suitable: ☐ yes ☐ no

Further investigations recommended: ☐ Ophtalmologist ☐ Optician

Workplace survey required: ☐ no ☐ yes, because of /problem-setting: _____

☐ No medical concerns

☐ No medical concerns under certain conditions

Comments:

FOLLOW-UP EXAMINATION: ---------/----------

Place, date: _____ Examiner: _____