Please return to W K H 2 I I L F H R I W K H 5 H J L V W U D U

Drop-off or mail: 6 -1000 KLO Road, Kelowna BC, V1Y 4X8

Email: D G P L V V @ N e l o w n a . b c . c a

Health Checklist to take to Doctors Office

Patient's name: _____

Doctor's name: _____

Please discuss the following with your patient:

Building Service Workers are exposed to various chemicals, lifting 50 lb. on several occasions during a shift, on their feet for long periods of time and do repetitive motions.

1. Do you have any allergies? Yes / No

If yes, what are you allergic to? _____

How do you react to allergic substances? _____

2. Recent surgery: Yes / No

If yes, please specify: _____

3. Do you have a history of:

Back problems? Yes / No

Repetitive strain injury? Yes / No

Joint problems? Yes / No

Chronic Skin Condition? Yes / No

4. Do you have a disability that may prevent you from:

Standing/walking for long periods of time? Yes / No / N o

_____

_____

_____

I have discussed all of the requirements listed on this form with my patient and certify that this person does not