

Today's date: __/__/__ Name of physician: _____ First Aider: _____ ENTRY ☐



EVREST 2024

Nom naiss Prénom Sexe M/F ☐ Date naiss
Dép. naissance Salarié ☐ Contrat : CDI ou assimilé ☐ Autre ☐ PCS-ESE
Entreprise NAF2008 Nb salariés
Etablissement de type : Privé ☐ Public ☐ Suivi individuel renforcé : oui ☐ non ☐
Atelier (facultatif) *Champ libre (facultatif)*
Entretien réalisé en présentiel ☐ distanciel ☐

Working Conditions

By completing this questionnaire, I acknowledge that I have read and accept the terms set out in the information sheet on the Evrest Observatory.

1. Do you work full time? Yes₁ ☐ No₀ ☐

2. Do you usually work standard working hours? Yes₁ ☐ No₀ ☐

Do you regularly have/do:

- Breaks longer than 2 hours Yes₁ ☐ No₀ ☐
- Unusual hours (early morning, late evening) Yes₁ ☐ No₀ ☐
- Irregular or rotating shifts Yes₁ ☐ No₀ ☐
- Night work (between 00.00 and 05.00) Yes₁ ☐ No₀ ☐

Are you regularly required to take business trips lasting for longer than 24 hrs? Yes₁ ☐ No₀ ☐

Currently you work: Exclusively on site₁ ☐ On site and telecommuting₂ ☐ Exclusively telecommuting₃ ☐

3. Time constraints:

a) Due to your workload do you ever:

	Never ₀	Rarely ₁	Quite often ₂	Very often ₃
- Work overtime	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Skip or shorten meal times, not take a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Complete an operation too quickly that actually requires more attention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Work at home on your time off	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

b) Can you rate the difficulties you encounter due to time pressure (having to hurry, doing everything very quickly, etc.)?

No difficulties ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Severe difficulties
(Circle the appropriate figure)

c) Do you frequently have to stop working on one task to complete another unforeseen task?

Yes₁ ☐ No₀ ☐

If yes, would you say that interrupting this activity:

- disturbs your work Yes₁ ☐ No₀ ☐
- is a positive aspect of your work Yes₁ ☐ No₀ ☐

4. Assessment of your work:

	No, not at all ₀	Mostly no ₁	Mostly yes ₂	Yes, absolutely ₃
- Your work provides opportunities to learn new things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Your work is varied	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- You can choose how you do things yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- You have enough possibilities to obtain help and cooperation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- You have the means to do your work to a high standard	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Your work is recognized by your professional entourage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- You have to do things you don't approve of	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- You work with the fear of losing your job	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- You are able to strike a good work-life balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Physical workload: does your job have the following characteristics?

	No never ₀	Yes sometimes ₁	Yes often ₂	If so, is it difficult or arduous?		
Awkward postures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If YES→	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Effort, Carrying heavy loads	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If YES→	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Repetitive movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If YES→	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Extensive walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If YES→	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Prolonged standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If YES→	Yes <input type="checkbox"/>	No <input type="checkbox"/>

7. Are you exposed to:

Yes ₁	No ₀	Yes ₁	No ₀	Yes ₁	No ₀	Yes ₁	No ₀
Chemical products	<input type="checkbox"/> <input type="checkbox"/>	Noise disturbances	<input type="checkbox"/> <input type="checkbox"/>	Severe heat	<input type="checkbox"/> <input type="checkbox"/>	Risk of infectious disease	<input type="checkbox"/> <input type="checkbox"/>
Dust, fumes	<input type="checkbox"/> <input type="checkbox"/>	Noise > 80db	<input type="checkbox"/> <input type="checkbox"/>	Severe cold	<input type="checkbox"/> <input type="checkbox"/>	Contact with public (users, patients, clients, pupils etc.)	<input type="checkbox"/> <input type="checkbox"/>
Ionizing rays	<input type="checkbox"/> <input type="checkbox"/>	Visual constraints	<input type="checkbox"/> <input type="checkbox"/>	Bad weather	<input type="checkbox"/> <input type="checkbox"/>		
Vibrations	<input type="checkbox"/> <input type="checkbox"/>	Driving for long periods	<input type="checkbox"/> <input type="checkbox"/>	Psychological pressure	<input type="checkbox"/> <input type="checkbox"/>		

Training – Management - Career path

- Have you done any training in the last year?

Yes₁ ☐ No₀ ☐

If yes, was it:

relevant to your current job Yes₁ ☐ No₀ ☐

relevant to a future position Yes₁ ☐ No₀ ☐
- Do you have a role as trainer or tutor?

Yes₁ ☐ No₀ ☐
- Do you have any employees under your orders or your authority?

Yes₁ ☐ No₀ ☐
- Have you changed your job in the last 2 years?

Yes₁ ☐ No₀ ☐

If so, did you do so for medical reasons? Yes₁ ☐ No₀ ☐
- Do you think that in the next two years your health state will allow you to continue your current job?

Certainly not₀ ☐ It's not sure₁ ☐ Yes, it's almost certain₂ ☐

Lifestyle

- Do you regularly (at least once a week) engage in any physical activity or sport?

Yes₁ ☐ No₀ ☐
- Usual consumption:

- Tobacco (no. of cig/day)

Non-smoker₀ ☐ Former smoker₁ ☐ < 5 cig₂ ☐ 5 to 15 cig₃ ☐ > 15 cig₄ ☐

- How often do you drink beverages containing alcohol?

Never or 1 x / month₀ ☐ 2 to 4 x / month₁ ☐ 2 to 3 x / week₂ ☐ 4 x / week or more₃ ☐

- On the days you drink alcohol how many standard-sized glasses do you consume?

Not concerned (teetotal)₀ ☐ 1 or 2₁ ☐ 3 or 4₂ ☐ 5 or 6₃ ☐ 7 to 9₄ ☐ 10 or more₅ ☐
- Do you have a long or arduous commute to work?

Yes₁ ☐ No₀ ☐

Current health status = last 7 days (to be completed by the physician or nurse)

Questionnaire renseigné par : le médecin₁ ☐ l'infirmier(e)₂ ☐ Nom IdEST

Dernier entretien santé-travail (hors reprise, à la demande, ...) il y a : ☐ ≤1 an ☐ 2 ans ☐ 3 ans ☐ 4 ans ☐ 5 ans ou + ☐ jamais

Poids : ___ kg Taille : ___ cm

		Plaintes ou signes cliniques au cours des 7 derniers j	Est-ce une gêne dans le travail ?	Traitement ou autre soin	(Colonne libre, facultatif)
RAS <input type="checkbox"/>	Cardio-respiratoire				
RAS <input type="checkbox"/>	- appareil respiratoire	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	_ _
RAS <input type="checkbox"/>	- appareil cardio-vasculaire	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	_ _
RAS <input type="checkbox"/>	- HTA	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	_ _
RAS <input type="checkbox"/>	Neuro-psychique				
RAS <input type="checkbox"/>	- fatigue, lassitude	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	_ _
RAS <input type="checkbox"/>	- anxiété, nervosité, irritabilité	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	_ _
RAS <input type="checkbox"/>	- troubles du sommeil	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	_ _
RAS <input type="checkbox"/>	Digestif	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	_ _
RAS <input type="checkbox"/>	Ostéo-articulaire				
RAS <input type="checkbox"/>	- épaule	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	_ _
RAS <input type="checkbox"/>	- coude	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	_ _
RAS <input type="checkbox"/>	- poignet / main	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	_ _
RAS <input type="checkbox"/>	- membres inférieurs	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	_ _
RAS <input type="checkbox"/>	- vertèbres cervicales	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	_ _
RAS <input type="checkbox"/>	- vertèbres dorso-lombaires	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	_ _
RAS <input type="checkbox"/>	Dermatologie	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	_ _
RAS <input type="checkbox"/>	Troubles de l'audition	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	Oui ₁ <input type="checkbox"/> Non ₀ <input type="checkbox"/>	_ _