PRE – EMPLOYMENT HEALTH ASSESSMENT

SECTION 1 – (Applicant to complete)

PERSONAL DETAILS	
Surname:	Given Names:
Former name:	Date of birth:
Postal address:	
Mobile:	Home telephone:

SECTION 2 – Office Staff to complete

IDENTIFICATION CHECK	
ID Type (Note: must be photo ID):	Licence No:
( ) Other ID — Type:	No:
Checked By - Name:	Signature:

Sections 3-5 The following health and medical questionnaire will ask you to answer questions regarding your present health and any past health concerns and occupational exposures. Please complete as accurately as possible. If you do not understand a question or are unsure of an answer, please leave blank and the nurse or doctor will assist you during the medical examination.

SECTION 3 – Applicant to complete

CURRENT MEDICAL CONDITIONS	MEDICATIONS AND TREATMENT (LIST ALL MEDICATIONS)

ONGOING WORK-RELATED INJURIES		
Date	**Injury**	**Treatment/ongoing issues**

SECTION 4 – Applicant to complete

MEDICAL HISTORY			
Are you now suffering from, or have you ever suffered from, any of the following? Answer either **YES —"Y"** or **NO – "N"** in the space provided — details of any YES responses should be written on the next page.			
1. Heart disease		**28.** Back or neck pain or injury	
2. Palpitations, extra or skipped heart beats		**29.** Tennis elbow or golfer's elbow	
3. Blood disease or disorder		**30.** Upper limb or shoulder pain	
4. High blood pressure		**31.** Any fractures	
5. Abnormal shortness of breath, leg pain or chest pain on exertion		**32.** Joint problems, pains, injuries, arthritis, dislocated joints	
6. Lung disease (e.g., asthma, bronchitis, emphysema, tuberculosis)		**33.** Occupational overuse syndrome (OOS) or Repetitive strain injury (RSI)	
7. Epilepsy, fainting attacks, fits, blackouts, or head injury		**34.** X-ray or MRI for back, neck or joint pain	
8. Dizziness or vertigo		**35.** Problems with balance or co-ordination	
9. Migraine or frequent headaches		**36.** Foot problems or problems with footwear	
10. Frequent coughing/bringing up phlegm		**37.** Skin Cancers	
11. Coughing and/or Shortness of Breath due to dust, fumes or gasses		**38.** Muscle or ligament strain	
12. Blood in urine		**39.** Weakness in arms or legs	
13. Stomach or duodenal ulcers or frequent indigestion		**40.** Varicose veins	
14. Hernia or rupture		**41.** Allergies (hay fever, sinusitis, urticarial/hives)	
15. Liver Disease (e.g. jaundice, hepatitis, cirrhosis)		**42.** Allergies to medication or chemical substances	
16. Kidney or bladder disease		**43.** Skin conditions (e.g. psoriasis, dermatitis, eczema)	
17. Sugar Diabetes		**44.** Abdominal pain or bowel disorder	
18. Thyroid Disease		**45.** Tenosynovitis or tendonitis	
19, Eye or vision problems (including wearing glasses or contact lenses)		**46.** Back pain lasting more than two weeks	
20. Hearing loss or deafness		**47.** Any form of cancer of tumour	
21. Night blindness or problem seeing at low levels of illumination		**48.** Any significant infectious illness or communicable disease	
22. Sensitivity to chemicals, dust, fumes, solvents or other substances		**49.** Have you had any operations or surgical treatment?	
23. Nervous, mental or psychiatric condition		**50.** Any abnormal blood or pathology tests	
24. Have you ever been admitted to hospital?		**51.** Has your weight altered in the last 12 months	
25. Are you currently receiving treatment including treatment from a person who is NOT a registered medical practitioner?		**52.** Have you been absent from work or full-time education through illness or injury for two or more weeks at any time?	
26. Are you taking any medication or receiving treatment (Please include items such as eye drops, asthma "puffers," nasal sprays, creams, vitamins physiotherapy, etc.)		**53.** Have you ever worked under conditions or with substances which may have been hazardous to your health? (e.g. toxic chemicals, noise, dusts, asbestos, radiation)	
27. Anxiety, stress reaction or depression		**54.** Any condition, complaint, ache, pain or disability not mentioned above	

PLEASE PROVIDE DETAILS OF ALL "YES" RESPONSES TO THE ABOVE RESPONSES IN SECTION 4

Question Number	Year/s Occurred	Provide brief description	Doctor's comments

SECTION 5 – Applicant to complete

HEALTH QUESTIONNAIRE	YES Or NO	If YES, please provide details	Doctor's comments
1. Do you, or have you ever, regularly smoked cigarettes?		Year started: Year stopped: How may per day: Type:	
2. Do you use any other inhaled tobacco or nicotine products, (vape, e-cigarettes, pipe, cigars etc)?		Type: How often would you use these?	
3. Do you drink alcohol? If YES please supply details.		How many drinks per week? _____	
4. Do you undertake any regular exercise? Please state type, frequency per week and duration of each session.		Type: Frequency: Duration:	
5. Have you been vaccinated against TETANUS in the last ten years?			
6. Have you been vaccinated against HEPATITIS B in the last 10 years?			

SECTION 6 – Applicant to complete

WORK CONDITIONS				
Have you previously had any problems with, or do you know of any reason as to why you may have problems with, the following?				
		Yes or No	**If Yes, please provide details**	**Doctor's comments**
1.	Are you now, or have you ever been, depended on or addicted to drugs or alcohol?			
Have you previously had problems with (or do you know of any reason why you may have problems with) any of the following?				
2.	Working at heights or on ladders			
3.	Working in confined spaces			
4.	Wearing protective equipment such as, safety glasses, helmets, face masks, safety footwear etc.			
5.	Working in wet or muddy conditions			
6.	Working in hot or cold environments			
7.	Working with chemicals, or other potential hazards			
8.	Working in dusty or noisy conditions			
9.	Performing heavy manual lifting or gripping			
10.	Working shift work			
11.	Any other capacity			

SECTION 7 – Applicant to complete with a witness present

MEDICAL DECLARATION AND AUTHORITY TO RELEASE INFORMATION
Declaration: I, **(insert name)** ……..hereby declare that the information given by me on this form is, to the best of my knowledge, true, correct, and complete. I am, to the best of my knowledge, able to perform the duties of the position I have applied for. I hereby give my consent for information contained in this health assessment and the doctor's medical assessment to be disclosed to my prospective employer for the purpose of assisting my appropriate placement in the workplace and to ensure the protection of the health and safety of myself and of others in the work environment. I acknowledge any false statement may be sufficient cause of rejection or, if employed, summary dismissal. I hereby authorise the following health professionals……to furnish to the Examining Doctor/Appointed Medical Adviser, medical information for the purpose of determining my fitness for employment. I understand that this information will be treated with the utmost respect for my personal privacy. I authorise this information to be released to my prospective employer.

Applicant Name:		**Applicant Signature:**	
Date:			
Witness Name:		**Witness Signature:**	
Date:			

SECTION 8 – Nurse or Examining Medical Officer to complete

EXAMINATION			
GENERAL MEASUREMENTS			
HEIGHT:		**BLOOD PRESSURE:**	/
WEIGHT:		**SECOND READING:**	/
BODY MASS INDEX (BMI)		**PULSE:**	BPM
HEALTHY / OVERWEIGHT / OBESE		REGULAR / IRREGULAR	

VISUAL ACUITY:

UNCORRECTED VISION		**CORRECTED VISION**	
Far Left 6 /	Far Right 6 /	Far Left 6 /	Far Right 6 /
Near Left N	Near Right N	Near Left N	Near Right N
HORIZONTAL FIELDS	☐ NORMAL	☐ ABNORMAL (TO CONFRONTATION)	
STRABISMUS	☐ NORMAL	☐ ABNORMAL	
COLOUR VISION / 12 PLATES		☐ NORMAL	☐ ABNORMAL
VISION IS: ☐ ADEQUATE ☐ ADEQUATELY CORRECTED ☐ NEEDS FURTHER EVALUATION			

URINALYSIS: (NIL, TRACE, +, ++, +++)

Protein: _____ **Blood: _____** **Glucose: _____** **Other: _____**

Blood Glucose (BSL)**:** mmol/L Specify:

SPIROMETRY:

RSHQ SPIROMETRY REGISTRATION NO:	P0005275	**PRE-SPIROMETRY CHECKLIST COMPLETED**	☐ YES ☐ NO

	Observed		**Lower Limit of Normal (LLN)**		**Predicted**		**Observed / Predicted (%)**	
FEV 1 (litres)	i.		iv.		vii.		x.	
FVC (litres)	ii.		v.		viii.		xi.	
FEV1 / FVC (%)	iii.		vi.		ix.		xii.	

OVERALL SPIROMETRY RESULT	☐ NORMAL	☐ ABNORMAL

AUDIOMETRY:

Hz →	500	1000	1500	2000	3000	4000	6000	8000
LEFT								
RIGHT								
WERE HEARING AIDS USED FOR THIS AUDIOGRAM? ☐ YES ☐ NO								
RESULT	☐ NIL LOSS		☐ MILD LOSS		☐ MODERATE LOSS		☐ OTHER	
AURISCOPE EXAMINATION:								
AUDITORY CANALS	☐ NORMAL ☐ ABNORMAL							
TYMPANIC MEMBRANES	☐ NORMAL ☐ ABNORMAL							

GENERAL EXAMINATION: (✓ = Yes or Normal ✗ = No or abnormal – comments required below*)

	✓✗		✓✗
1. Physique/muscular development		**15.** Scars/deformity	
2. Cardiovascular system		**16.** Behaviour during examination	
3. Radial pulse / peripheral pulse		**17.** Musculoskeletal/spine	
4. Peripheral circulation/veins			
5. Respiratory system		**NERVOUS SYSTEM**	
6. Abdomen		**18.** Movement normal (tremor, tics, etc.)	
7. Hernial orifices		**19.** Coordination normal (finger-nose test)	
8. Lymph nodes		**20.** Balance (Sharpened Romberg test**)	
9. Eyes / fundi		**21.** Perform fine motor tasks (e.g. draw a six-pointed star)	
10. Ears / nose / throat / tongue / teeth /gums			
11. Skin			
12. Pupillary reflexes			
13. Hair and Nails			
14.CNS			

***The sharpened Romberg test is performed by having the subject stand on a hard floor, barefoot, with the feet heel to toe in a straight line and the arms crossed over the chest. When steady in this position, close the eyes. Once the eyes are closed, the ability to maintain balance is timed. A number of attempts may be required for the individual to maintain stability. A normal result is 30 seconds or more.*

DOCTOR'S COMMENTS ON ANY ABNORMAL FINDINGS (Attach sheet if space is insufficient)

Item No.	Comments

SECTION 9 – Examining Medical Officer to complete

PRE-EMPLOYMENT HEALTH ASSESSMENT REPORT

(Medical advisor to complete)

Applicant's Details

Surname	Given Name/s

Examination Details

Date of Examination	Proposed Position

The above person has been assessed regarding his/her suitability to perform the duties of the above-mentioned position in accordance with the appropriate medical fitness standards.

ASSESSMENT / OPINION

Does this individual appear to suffer from any condition which may reduce his/her ability to effectively perform the duties of the proposed position?	NO / YES
Does this individual appear to suffer from any condition which may reduce his or her ability to ***safely*** perform the duties of the proposed position?	NO / YES
Does this individual appear to suffer from any condition which may be aggravated as a result of the proposed position?	NO / YES
If YES to any of the above, please comment (including information regarding possible control measures taking into account the principle of reasonable adjustment)	
Comments:	
The following results are attached: ☐ Audiometry ☐ Spirometry ☐ Drug & Alcohol ☐ Other	

This assessment does not address the applicant's suitability for the proposed position by virtue of education, vocational training, aptitude, or skill. Please contact the Examining Medical Officer if further clarification or advice is required.

Signed		**Date**	
Examining Medical officers Stamp		**Distribution of this Form:** (a) Original to Employer (b) Photocopy to remain on medical file	