Medical

Employee

Last Name		Mobile	
First Name		Home	
Date of Birth		Email	

Type of Medical	
Billing policy:	

The purpose of this examination is to make sure that you can do your job without any risk to you or your colleagues' health.

To assess this risk, we need to know about your past medical history, your working history, your current health status, and various other factors that may impact on your personal risk profile. We will perform this examination prior to you commencing work and regularly during your working life with the company. We recommend that you be examined on your exit from the company too, to document any possible work related health problems that might have occurred during your period of employment. Any information that you provide about your health will be treated in the strictest confidence, and in accordance with the highest ethical standards.

Declaration

I. I declare that the information I have provided in this questionnaire is true and correct to the best of my knowledge.
II. I give permission for examining doctor to obtain any medical information about me relevant to providing an assessment of my capacity to perform in this position
III. Personal medical information will only be provided to anyone after your specific consent has been obtained.
IV. Access to medical information in your file is only available to registered clinical staff, who are bound by strict ethical rules regarding confidentiality.
V. I authorize the examining doctor to release the results of my medical examination and any information relevant to my capacity to perform the requirements of this position.

Candidates Signature		Date	

The Privacy of the personal information supplied by the applicant in the application, interview, assessment and checking process will be respected in all circumstances and will be managed in accordance with the obligations imposed by the Privacy Act 1988.

PART B: Applicant Report — TO BE COMPLETETD BY APPLICANT

1. Personal Details

Surname: _____ Other Names: _____

Date Of Birth: ____/____/____ Telephone No: _____

Address: _____

_____ Post Code: _____

Date of Examination: _____/____/____

2. Personal Health History

	Yes	No	If yes, give details
Are you currently being treated by any other doctor for any illness?.....	☐	☐	
Are you currently taking any medications, either prescribed by a doctor or over the counter including inhalers?	☐	☐	
Are you allergic to anything?	☐	☐	
Have you ever spent time in hospital as a patient?	☐	☐	
Have you broken or fractured any bones?	☐	☐	
Have you ever had a disease or injury resulting from work?	☐	☐	
Do you suffer from back, neck or spinal problems, including whiplash?	☐	☐	
Have you visited a chiropractor or physiotherapist in the last year?	☐	☐	
Have you ever had an X-ray or scan of your neck or back?	☐	☐	
Have you ever had trouble wearing any personal protective equipment? ...	☐	☐	
Have you, in the last two years, lost time from work because of illness o r injury?.....	☐	☐	
Have you ever been exposed to any toxic substances or environmental hazards?.....	☐	☐	
Do you suffer or have ever suffered from RSI, occupational over-use syndrome, tennis elbow or tenosynovitis?.....	☐	☐	
THE FOLLOWING QUESTIONS APPLY ONLY TO PERSONS APPLYING FOR JOBS INVOLVING WORK AT HEIGHT			
Have you suffered any injury or illness, or do you currently have any health problems, which you feel might prevent you climbing or working at height?.	☐	☐	
Do you have a history of high cholesterol or triglycerides?……..	☐	☐	
Do you have a family history of heart disease?……..	☐	☐	
Do you have any Surgically Implanted Medical Devices (SIMD's). If "YES" please list the device and discuss with the assigned practitioner to determine the medical risks associated with becoming a worker……..	☐	☐	

3. Do you now, or have you ever had any of the following? (please tick box)

	Yes	No		Yes	No		Yes	No
Tuberculosis	☐	☐	Hernia	☐	☐	Dermatitis/ eczema psoriasis	☐	☐
Rheumatic Fever	☐	☐	Earache	☐	☐	Head Injury, or concussion	☐	☐
Hay Fever	☐	☐	Discharging ears	☐	☐	Foot trouble	☐	☐
Wheezing/ Asthma	☐	☐	Hearing defect	☐	☐	Malaria, other tropical diseases	☐	☐
Heart trouble, angina, chest pain	☐	☐	Depression	☐	☐	Frequent or migraine headaches	☐	☐
Palpitations/irregular heart beats	☐	☐	Anxiety	☐	☐	Other joint injuries or conditions	☐	☐
Heart Murmurs	☐	☐	Stress	☐	☐	Ankle or knee trouble	☐	☐
Shortness of breath	☐	☐	Other mental disorder	☐	☐	Bruising or excessive bleeding	☐	☐
High blood pressure	☐	☐	Blackouts / fainting	☐	☐	Recent weight gain /loss	☐	☐
Arthritis	☐	☐	Hepatitis /Jaundice	☐	☐	Severe injury or operation	☐	☐
Back pain, back injury sciatica	☐	☐	Stomach or duodenal ulcers.	☐	☐	Cancer or tumour of any kind	☐	☐
Eye trouble	☐	☐	Passing or vomiting blood	☐	☐	HIV	☐	☐
Epilepsy / Fits	☐	☐	Kidney / Bladder problems	☐	☐	Diabetes	☐	☐

4. Do you now, or have you ever had any of the following (please tick box)

Do you:

Yes	No		Yes	No	
☐	☐	Engage in regular exercise	☐	☐	Do you smoke, or have you ever smoked in the past? _____
☐	☐	Take illicit drugs? _____			
☐	☐	Drink alcohol? If yes, average number of drinks per week _____			
☐	☐	Have any illness or injuries not stated above? If yes, provide details _____			

Do you have difficulty with any of the following:

	Yes	No		Yes	No		Yes	No
Crouching	☐	☐	Bending repeatedly	☐	☐	Standing for extended periods	☐	☐
Lifting heavy weight	☐	☐	Sitting for extended periods	☐	☐	Repetitive movement of hands/arms	☐	☐
Heights	☐	☐	Shift-work	☐	☐	Confined spaces	☐	☐
Walking up the stairs	☐	☐	Kneeling	☐	☐		☐	☐

When and where was your last chest x-ray taken? _____

When was your last tetanus injection? _____

Do you have, or have had, any other condition not mentioned above that may impact upon your ability to safely perform the duties required of you? _____

5. Occupational History

Previous Employment Details (Previous 2 years only – most recent first)

Company Name	Length of Employment	Industry Type	Position

1.	Are you currently being treated by a doctor for any medical and/or psychological condition?	YES	NO
2.	Are you currently on any medication, either prescription or over the counter?	YES	NO
3.	Have you had any significant illness, admission to hospital and/or surgical procedures in the past 5 years (excluding normal pregnancy and delivery)?	YES	NO
4.	Have you ever had a workers compensation claim or suffered a work related injury?	YES	NO
5.	Do you have a current workers compensation claim?	YES	NO
6.	Have you ever had an extended period of 2 weeks or more off work due to injury, illness and/or conditions?	YES	NO
7.	Have you visited a therapist in the past 12 months, such as physiotherapist or chiropractor?	YES	NO
8.	Is there any other past or present condition(s) which may prevent you from performing the requirements of the job?	YES	NO

If YES to any of the above, please provide details:

_____

_____

_____

Assessor's comments:

_____

_____

_____

I hereby certify that the foregoing particulars are to the best of my knowledge correct. I authorise

_____ **to release any information acquired from this examination to my employer/ Prospective employer**

[insert medical practitioners name]

Signature _____ Date _____/_____/_____

Occupational Medical Assessment

PART C: Medical Report TO BE COMPLETED BY MEDICAL PRACTITIONER ONLY

1. Measurements

Height _____ Weight _____ Body Mass Index _____

Urinalysis

Blood _____ Sugar _____ Protein _____

Visual Acuity

Distance vision

Corrected			Uncorrected		
Right	6		Right	6	
Left	6		Left	6	
Both	6		Both	6	

Close vision

Corrected			Uncorrected		
Right	N		Right	N	
Left	N		Left	N	
Both	N		Both	N	

Colour vision

Plate Number	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24

Normal _____ Abnormal _____

Spirometry – if required (attach Report)

FEV _____ FVC _____ FEV/FEC Ratio _____

Normal _____ Abnormal _____ Report Attached _____

Blood Pressure

BP Additional readings if required

Pulse Rating

Resting _____

Pulse Rhythm

Regular Yes ☐ No ☐

Electrocardiogram - if required (Attach Report)

Normal _____ Abnormal _____ Report Attached _____

2. General

	Yes	No	Provide details if required
1. Does the appearance correspond with age started?	☐	☐	_____
2. Is there anything unfavourable in appearance, physique or development?	☐	☐	_____
3. Is there a reason to suspect intemperate habits?	☐	☐	_____
4. Give particulars of permanent marks or scars by which the person could be identified.	☐	☐	_____
5. Any dermatitis, skin rash, infection?	☐	☐	_____

Occupational Medical Assessment – PART C cont

3. Respiratory System

	Yes	No	Provide details if required
1. Is breathing normal and regular in character?	☐	☐	_____
2. Is there any abnormality on inspection or examination?	☐	☐	_____
3. Is there any sign of past or present respiratory disease?	☐	☐	_____

4. Circulatory System

	Yes	No	Provide details if required
1. Are there any abnormalities on cardiac auscultation?	☐	☐	_____
2. Is there any abnormality in the heart rate or rhythm?	☐	☐	_____
3. Do you consider the heart and vascular system to be perfectly healthy?	☐	☐	_____

5. Digestive System

	Yes	No	Provide details if required
1. Is there evidence of abnormality for:			
Tongue	☐	☐	_____
Mouth	☐	☐	_____
Teeth	☐	☐	_____
Throat	☐	☐	_____
2. Is there any evidence of abnormality for: Abdominal organs, including liver and spleen	☐	☐	_____
3. Is a hernia present?	☐	☐	_____

6. Spine and Nervous System

	Yes	No	Provide details if required
1. Is there any evidence of disease of the brain, nerves or spinal cord?	☐	☐	_____
2. Is there any defect in sight, hearing or speech?	☐	☐	_____
3. Is there evidence of abnormality for:			
Shoulders	☐	☐	_____
Elbows	☐	☐	_____
Wrists	☐	☐	_____
Hands	☐	☐	_____
Hips	☐	☐	_____
Knees	☐	☐	_____
Ankles	☐	☐	_____
Feet	☐	☐	_____

Occupational Medical Assessment – Part C cont

6. Spine and Nervous System – CONT.

3. Is there evidence of abnormality for: (continued)	Yes	No	Provide details if required
Cervical Spine	☐	☐	_____
Thoracic Spine	☐	☐	_____
Lumbar Spine	☐	☐	_____

4. Reflexes: Is there evidence of abnormality for:			
Biceps	☐	☐	_____
Triceps	☐	☐	_____
Supinator	☐	☐	_____
Knee	☐	☐	_____
Ankle	☐	☐	_____

5. SRL: L: _____ degrees R: _____ degrees

6. Posture: Good _____ Average _____ Poor _____

7. Balance (Rhombergs) _____

7. Audiometry - if required (Hearing Testing):

Left Ear							Right Ear						
500	1000	2000	3000	4000	6000	8000	500	1000	2000	3000	4000	6000	8000

8. Any other conditions, disabilities or comments – Current or potential?

_____

_____

PART D: PATIENT SUMMARY TO BE COMPLETED BY MEDICAL PRACTITIONER ONLY

1. Patients Details

Surname: _____ Other Names: _____

Address: _____

_____ Postcode: _____

Date of Examination: _____/_____/_____

2. Type of Examination Performed

Employment Medical	☐	Chest X-ray	☐
Baseline Hearing Test	☐	Musculo Skeletal	☐
Drug and Alcohol Screen	☐	Scuba	☐
Spirometry	☐	H.U.E / IFAP medical	☐
Mine Worker's Health Surveillance	☐	Blood Test	☐
Mines Rescue	☐	Other	☐

3. Drug Results – attach report (if requested)

No substances detected ☐ Substances detected ☐

Comments: _____

4. I am of the opinion that the above mentioned person is:

☐ Fit for proposed employment

☐ Fit for proposed employment with the following restrictions:

_____

☐ Fit for proposed employment conditional on the following information being made available:

_____

5. Doctor's details

Name: _____

Address: _____

Signature: _____

Telephone: _____ Date: ____/____/____

The examining doctor wishes to make it known that the purpose of this examination and the consequent opinions expressed are in the interests of prevention of occupational injury by the proper placement of employees in those positions best suited to their physical capabilities. This examination is not for the purpose of determining the success or otherwise of this person's application for employment.