PRE-EMPLOYMENT MEDICAL EXAMINATION

FULL NAME: ____

DATE OF BIRTH: ____/____/____

ADDRESS:____

SUBURB: ______________________ STATE: _________ POSTCODE:________

HOME PH: ___________________ MOBILE: ____________________

USUAL FAMILY DOCTOR:____

DOCTORS ADDRESS: ____

DOCTORS PHONE NO: ____

POSITION APPLIED FOR: ____

MEDICAL QUESTIONNAIRE

		Please circle:		If "yes", give details:
1	Are you allergic to any medicines, food or other items?	*NO*	*YES*	………………………
2	Are you taking any other medications?	*NO*	*YES*	………………………
3	Do you drink alcohol?	*NO*	*YES*	………………………
4	Do you have any vision or eye problems?	*NO*	*YES*	……………………...
5	Do you wear contacts or glasses at work?	*NO*	*YES*	………………………
6	Have you ever had a hearing or other ear problem?	*NO*	*YES*	………………………
7	Has your weight altered in the last year?	*NO*	*YES*	………………………
8	Have you been exposed to chemicals, solvents, noise, asbestos or dusts?	*NO*	*YES*	………………………
9	Have you ever had a head injury or concussion?	*NO*	*YES*	………………………
10	Have you ever had any broken bones?	*NO*	*YES*	………………………
11	Have you ever had any joint pains, swelling or arthritis?	*NO*	*YES*	………………………
12	Have you ever had any operations?	*NO*	*YES*	………………………
13	Have you ever had back trouble?	*NO*	*YES*	………………………
14	Have you ever had chest pain?	*NO*	*YES*	………………………
15	Have you ever had depression or other mental illness?	*NO*	*YES*	………………………
16	Have you ever had dermatitis, eczema or other skin rash?	*NO*	*YES*	………………………
17	Have you ever had diabetes?	*NO*	*YES*	………………………
18	Have you ever had fits or convulsions?	*NO*	*YES*	………………………
19	Have you ever had heart trouble?	*NO*	*YES*	………………………
20	Have you ever had a hernia?	*NO*	*YES*	………………………

21	Have you ever had high blood pressure?	*NO*	*YES*	………………………
22	Have you ever had migraine or frequent headaches?	*NO*	*YES*	………………………
23	Have you ever had wheezing, bronchitis, asthma or hay ever?	*NO*	*YES*	………………………
24	Have you ever had an ulcer?	*NO*	*YES*	………………………
25	Have you ever had an illness requiring treatment for more than one week?	*NO*	*YES*	………………………
26	Have you ever smoked cigarettes?	*NO*	*YES*	………………………..
27	Do you smoke cigarettes now?	*NO*	*YES*	………………………..
28	Have you had any x-rays?	*NO*	*YES*	………………………
29	Have you ever received Workers' Compensation payments?	*NO*	*YES*	………………………

30 Previous immunisation history

Immunisation ………………………… *Date Given …./…./……*

Immunisation ………………………… *Date Given …./…./……*

Immunisation ………………………… *Date Given …./…./……*

URINE
PROTEIN __________
SUGAR __________
BLOOD __________

***Please perform instant Drug Screen**

HEIGHT ___________ **WEIGHT**____________ **BMI** _____

BLOOD PRESSURE

SYSTOLIC ______________
DIATOLIC ______________
PULSE ______________ REGULAR IRREGULAR

VISUAL ACUITY

RIGHT	_6/_______	_N____________
LEFT	_6/_______	_N____________

ISHIHARA Pass Fail

HEART	**NORMAL**	**ABNORMAL**
CHEST	**NORMAL**	**ABNORMAL**
ABDOMEN	**NORMAL**	**ABNORMAL**
HERNIAS	**NORMAL**	**ABNORMAL**
SPINE/BACK	**NORMAL**	**ABNORMAL**
JOINTS	**NORMAL**	**ABNORMAL**
SKIN	**NORMAL**	**ABNORMAL**
ALCOHOL & DRUG SIGNS OF	**NORMAL**	**ABNORMAL**

PRIVACY INFORMATION

I consent to DOCTORS SURGERY collecting and using my personal information on the basis of conducting a health assessment and understand that it will be subject to the Privacy Policy described above. I also understand that any results or questionnaires will be held confidentially and will only be reported to my employer or their representative in terms of my fitness for duty.

I acknowledge that the information I have provided is true and complete in every manner, and that DOCTORS SURGERY is not liable in any respect of any employment consequences that may arise from false statements, responses, or omissions made by me in this questionnaire.

I acknowledge that DOCTORS SURGERY and the examining Doctor shall not, under any circumstances, be considered in any way responsible for the success or otherwise of my employment application and that any decisions will be based on the selection criteria of the Employer requesting the health assessment.

Client Signed…………………………………………………………..

Date………………………………

RANGE OF MOVEMENT

SPINAL COLUMN:

Restricted: YES NO

Comments to Yes Answers…………………………………………………………………..….

…………………………………………………………………………………………………

SHOULDER GIRDLE:

Restricted: YES NO

Comments to Yes Answers………………………………………………………………..……….

…………………………………………………………………………………………………

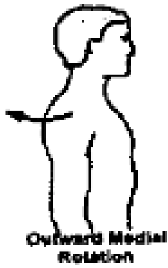
SAFETY BARRIER SOLUTIONS

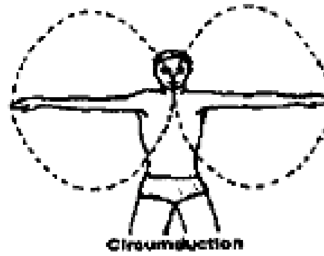
SHOULDER:

Restricted: YES NO

Comments to Yes Answers……………………………………………………………………..

…………………………………………………………………………………………………



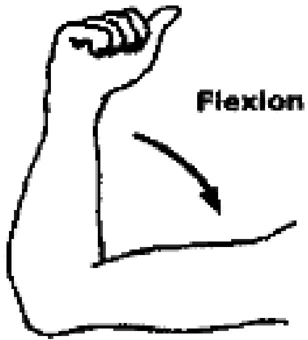


Restricted: YES NO

Comments to Yes Answers……………………………………………………………………..

…………………………………………………………………………………………………

ELBOW:



Yes No

Restricted: YES NO

Comments to Yes Answers…………………………………………………………………..

……………………………………………………………………………………………………

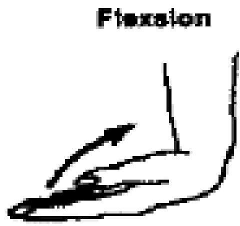
WRIST JOINT:

Restricted: YES NO

Comments to Yes Answers…………………………………………………………………..

……………………………………………………………………………………………………

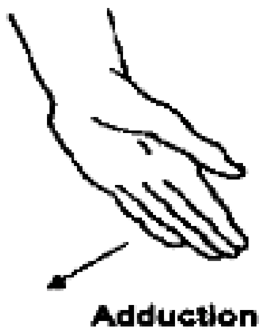
WRIST JOINT CONTINUED:

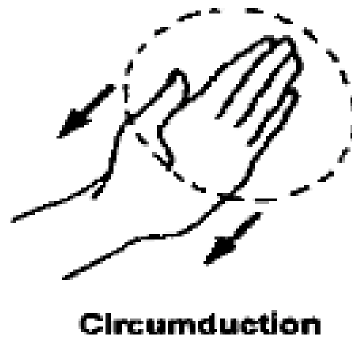


Restricted: YES NO

Comments to Yes Answers…………………………………………………………………..

……………………………………………………………………………………………………





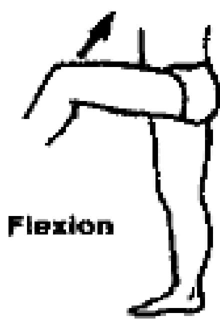
Restricted: YES NO

Comments to Yes Answers…………………………………………………………………..

……………………………………………………………………………………………………

SAFETY BARRIER SOLUTIONS

HIP JOINT:



Restricted: YES NO

Comments to Yes Answers……………………………………………………………………..

…………………………………………………………………………………………………

Restricted: YES NO

Comments to Yes Answers……………………………………………………………………..

…………………………………………………………………………………………………

DOCTORS COMMENTS:

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I have examined ___________________________ .

I am aware that the candidate will be required to perform various manual tasks including lifting, carrying, pulling, pushing, restraining and lowering of various heavy objects in accordance with correct manual handling techniques;

and I find him/her MEDICALLY FIT or MEDICALLY UNFIT for these duties.

Signed (DOCTOR) _____________________ Date ___/___/___