Pre-Employment Medical Form

PART A: APPLICANT DETAILS & HISTORY

1 Applicant Details

☐ Mr ☐ Mrs ☐ Ms ☐ Miss

Height (cm): Weight (kg):

Surname (Family Name)

Given Names (In Full)

Current Residential Street Address

Postal Address

Email Address

Mobile Phone

Home Phone

Date of Birth

Gender

☐ Male ☐ Female

GP's Name (MUST BE FILLED)

GP's Address / Clinic Name

2 Employment History (Minimum 5 Years)

Employer (from most recent)	Position Title	Time period: From – To (mm/yy – mm/yy)

3 Recreational Activities / Fitness

Activity	Duration	Times per Week

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4 Medical History

Do you have or have you ever had?	Yes	No
4.1 Allergies including to drugs; animals; bee stings; pollens; grass; food; rubber; chemical	☐	☐
4.3 Heart conditions (heart attacks; angina; high/low blood pressure; murmur; palpitations; chest pain, etc.)	☐	☐
4.5 Stroke; clots in legs or lungs; excessive bleeding or bruising; DVT; varicose veins	☐	☐
4.7 Nervous System Disorder (paralysis; blackouts; dizzy spells, fainting or attacks of unconsciousness; epilepsy; muscular weakness; numbness in fingers/hands; coordination problems)	☐	☐
4.9 Ear conditions; restricted hearing; tinnitus; ear infections; hearing loss; hearing difficulties	☐	☐
4.11 Migraine; persistent headaches; head injury; concussion	☐	☐
4.13 Chronic fatigue lasting greater than 6 weeks	☐	☐
4.15 Hernia	☐	☐
4.17 Kidney / Bladder conditions (kidney stones; urinary infection; prostate problem)	☐	☐
4.19 Arthritis, gout, joint pain or swelling	☐	☐
4.21 Feet problems, ankle problems or foot pain on standing or walking	☐	☐
4.23 Shoulder pain, tendonitis or frozen shoulder	☐	☐
4.25 Back / Neck problems (disc problems; prolonged back /neck pain; whiplash; sciatica or leg pain)	☐	☐
4.27 Rheumatic fever	☐	☐
4.29 Broken bones or fractures	☐	☐
4.31 Skin Conditions (Eczema; Dermatitis; rash; Psoriasis; recent skin infection; Skin Cancer)	☐	☐
4.33 Lung Conditions (Asthma; Bronchitis; Pleurisy; Tuberculosis; coughing up blood; persistent cough; chest complaints; shortness of breath; Silicosis; Asbestosis; other)	☐	☐
4.35 Diabetes or thyroid problem (over / under active thyroid)	☐	☐
4.37 Other conditions that may require medical management onsite (relevant to remote locations)	☐	☐
4.39 In the past 4 weeks have you taken any pain medication containing codeine, cold and flu medication, anti-anxiety medication, sleeping tablets or sedatives?	☐	☐

Do you have or have you ever had?	Yes	No
4.2 Cancer or other tumours	☐	☐
4.4 A pace maker or any other implantable device	☐	☐
4.6 Do you wear glasses/contact lenses?	☐	☐
4.8 Eye conditions (restricted vision; Glaucoma Iritis; colour blindness; other)	☐	☐
4.10 Do you wear hearing aids?	☐	☐
4.12 Mental Illness / stress (nervous breakdown; mental fatigue; anxiety; depression; panic attacks; self-harm; significant sleep disturbance; eating disorders; fear; phobias to travel or confined spaces; schizophrenia; bipolar)	☐	☐
4.14 Sleep disorder; Issues with sleep or excessive fatigue when performing shift work?	☐	☐
4.16 Digestive system conditions (Colitis; frequent diarrhoea; Gastric/Duodenal Ulcer; IBS; Hepatitis; Liver complaints / Jaundice; pancreatitis)	☐	☐
4.18 History of Tropical / Infectious Diseases including Malaria; Hepatitis; Tuberculosis (TB), Dengue Fever	☐	☐
4.20 “Repetitive strain injury” such as tendonitis, tennis elbow, golfers elbow, Carpal tunnel syndrome or any other over use condition	☐	☐
4.22 Knee injury, swelling or pain	☐	☐
4.24 Have you consulted your GP in the last 12 months?	☐	☐
4.26 Are you receiving medical treatment at the present time?	☐	☐
4.28 Do you expect to consult your Doctor or expect to receive any treatment in the near future?	☐	☐
4.30 Do you currently have any work restrictions certified by a Doctor?	☐	☐
4.32 Have you spent any time in hospital other than already stated?	☐	☐
4.34 Have you visited a therapist e.g. Physiotherapist, Osteopath, Chiropractor etc. in the last year?	☐	☐
4.36 Have you ever had an X-ray, CT scan, Ultrasound, MRI scan?	☐	☐
4.38 Is there any history of serious illness or disease in your family?	☐	☐
4.40 Do you take regular medication?	☐	☐

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Do you have or have you ever had?	Yes	No
4.41 Take medication to help you sleep or remain alert or awake?	☐	☐

Do you have or have you ever had?	Yes	No
4.42 Hold a conditional Driver's Licence (with restrictions or conditions due to medical condition), or have a condition you should report to the licensing authority	☐	☐

4.1 Additional Information

You **must** provide details to any questions answered YES on previous page.
Doctor to make further comment if appropriate

Question Number	Onset / Cessation of Condition (dates)	Details (please include diagnosis, any ongoing symptoms, treatment, specialist details, frequency of review with a doctor and/or specialist and medication)

5 Work Related Health History

	Yes	No
5.1 Have you ever had any disease or injury arising out of your work e.g. deafness, backache, dermatitis, asthma, vibration white finger or any other work related health conditions?	☐	☐

If yes please provide details below

Injury type/ body location	Date of onset	Date injury/ illness resolved	Treatment received/ doctor seen	Amount of time required off work

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		Yes	No	If yes please provide details below
5.2	Have you ever experienced conflict or stress at work that required medical treatment or counselling?	☐	☐	
5.3	Have you ever left, or been denied a job on health grounds?	☐	☐	
5.4	Have you ever been refused life / disability insurance or military service for medical reasons?	☐	☐	
5.5	Have you ever been denied a driving license on health grounds?	☐	☐	
5.6	Have you ever been advised for medical reasons not to do night work, shift work, or any other kind of work	☐	☐	
5.7	Is there any reason why you cannot wear personal protective equipment (PPE)? (steel capped boots; gloves; glasses / goggles; ear plugs / muffs; helmet; respiratory mask; full safety harness)	☐	☐	
5.8	Have you ever undergone health surveillance due to hazards in your previous job?	☐	☐	
5.9	Have you ever worked in a dusty or noisy environment?	☐	☐	
5.10	Have you ever worked with x-rays or other forms of radiation?	☐	☐	
5.11	Have you ever worked with vibrating tools?	☐	☐	
5.12	Have you ever worked with chemicals? If so what chemicals?	☐	☐	
5.13	Have you ever lodged a Workers Compensation Claim?	☐	☐	
5.14	Do you have a current Workers Compensation Claim?	☐	☐	

6 Vaccination History

Have you had the following Vaccinations?	Yes	No	If Yes, list the date
Tetanus	☐	☐	
Hepatitis A	☐	☐	
Hepatitis B	☐	☐	
Other	☐	☐	

State Vaccination

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7 Social History

	Yes	No	If yes please indicate	
7.1 Do you currently smoke?	☐	☐	Daily amount and age you started:	
7.2 Have you ever smoked?	☐	☐	Daily amount and age you ceased:	
7.3 Do you bite your fingernails?	☐	☐	N/A	

8 Physical Details

Do you have difficulties with the following activities?	Yes	No	Do you have difficulties with the following activities?	Yes	No
8.1 Running 100 metres	☐	☐	8.2 Walking on rough or uneven ground	☐	☐
8.3 Kneeling or crouching	☐	☐	8.4 Standing or sitting for 2 hours or more	☐	☐
8.5 Climbing stairs or ladders	☐	☐	8.6 Lifting or bending	☐	☐
8.7 Using hand tools	☐	☐	8.8 Gripping firmly with both hands	☐	☐
8.9 Repetitive movement of hands or arms	☐	☐	8.10 Confined spaces or working at heights	☐	☐
8.11 Working in extremes of temperature	☐	☐	8.12 Shift work	☐	☐
8.13 Concentrating on a task	☐	☐	8.14 Turning your head rapidly	☐	☐
8.15 Reading ordinary print	☐	☐	8.16 Understanding English including reading signs	☐	☐
8.17 Hearing a normal conversation	☐	☐	Hand dominance ☐ Right	☐	Left

8.1 Additional Information

Question Number	Details / Comments

9 Stress Assessment

Kessler 10 – Psychological Distress Scale In the past 4 weeks:	5 All of the time	4 Most of the time	3 Some of the time	2 A little of the time	1 None of the time
About how often did you feel tired out for no good reason?	☐	☐	☐	☐	☐
About how often did you feel nervous?	☐	☐	☐	☐	☐
About how often did you feel so nervous that nothing could calm you down?	☐	☐	☐	☐	☐
About how often did you feel hopeless?	☐	☐	☐	☐	☐
About how often did you feel restless or fidgety?	☐	☐	☐	☐	☐
About how often did you feel so restless you could not sit still?	☐	☐	☐	☐	☐

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Kessler 10 – Psychological Distress Scale In the past 4 weeks:	5 All of the time	4 Most of the time	3 Some of the time	2 A little of the time	1 None of the time
About how often did you feel depressed?	☐	☐	☐	☐	☐
About how often did you feel that everything was an effort?	☐	☐	☐	☐	☐
About how often did you feel so sad that nothing could cheer you up?	☐	☐	☐	☐	☐
About how often did you feel worthless?	☐	☐	☐	☐	☐
Score					

Comments if applicable: _____

10 Fatigue Assessment

Question	Yes	No	If Yes, provide comment
Have you ever had or been told by a Doctor you had a sleep disorder, sleep apnoea or narcolepsy?	☐	☐	
Has anyone noticed your breathing stops or disrupted episodes of choking during your sleep?	☐	☐	

Epworth Sleepiness Scale	How likely are you to doze or fall asleep in the following situations in contrast to feeling just tired?	
Use the following scale to choose the most appropriate response for each situation: 0 = would never doze off 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	**Chance of Dozing:**	Score (0,1,2,3)
	Sitting and reading	
	Watching TV	
	Sitting, inactive in a public place (e.g. theatre or meeting)	
	As a passenger in a car for an hour without a break	
	Lying down to rest in the afternoon when circumstances permit	
	Sitting and talking to someone	
	Sitting quietly after a lunch without alcohol	
	In a car while stopped for a few minutes in the traffic	
	Total	

11 Declaration and Authority to Release Information

The Workers' Compensation and Injury Management Act provides for penalty or rejection of a claim where false or misleading information is given as per section 79:

WORKERS' COMPENSATION AND INJURY MANAGEMENT ACT 1981 - SECT 79

Wilful and false representation by worker

- Where it is proved that the worker has, at the time of seeking or entering employment in respect of which he claims compensation for an injury, wilfully and falsely represented himself as not having previously suffered from the injury an arbitrator may in the arbitrator's discretion refuse to award compensation which otherwise would be payable.

  [Section 79 amended by No. 48 of 1993 s. 28(1); No. 42 of 2004 s. 63, 146 and 147.]
- Failure to answer all questions fully may invalidate the pre selection process and result in your application for employment being disregarded.
- All medical information collected shall be held in strict confidence and in accordance with Privacy legislation.

I hereby certify that to the best of my knowledge and belief, the answers given by me are true and correct.
I have read and understood the information above. Authority is given by me for the Company's Medical Officers and/or Injury Management Superintendent to make any enquiries considered necessary to accurately establish my medical history and fitness for work in the position I have applied for, and to make disclosure of any relevant assessment to the Company.

Name:		Signature:		Date:	