Medical History

SECTION 1: Personal Information						
Surname		Given Name		DOB		M ☐ F ☐
Home Address				Post Code		
Contact No		Email Address				
Emergency Contact Name		Relationship		Contact No		
Proposed Occupation			Job Location			

SECTION 2: Work History

Please complete the below table in relation to your work/employment history over the past 2 years

Occupation/Job Role	Start Date	End Date	Employer

Is the job you are applying for the same type of work you are now doing?	Yes ☐ No ☐
Have you previously worked in the same work environment as this job?	Yes ☐ No ☐

Examiner Comments: (Please comment on all YES answers)

SECTION 3: Medication

Please list any medications you are currently taking below (eg. Tablets, pills, injections, puffers or aspirin)

Name of Medicine	Reason (eg. high blood pressure)	Date Commenced	Taken Regularly?
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐

Examiner Comments: (Please comment on all YES answers)

Patient Initials: _____

Total Health Solutions REDIMED

Medical History

SECTION 4: General Health

Have you seen your doctor in the last 6 months concerning your health?	Yes ☐ No ☐
Has your weight altered much in the last 2 years?	Yes ☐ No ☐
Have you ever had any serious injuries, illness, mental or physical, which required medical treatment for a period of one week or more?	Yes ☐ No ☐
Have you ever spent time in hospital?	Yes ☐ No ☐
Have you ever had a blood transfusion?	Yes ☐ No ☐

Do you have OR have you ever had any of the following?

Diabetes	Yes ☐ No ☐	Concussion or head injury	Yes ☐ No ☐
High blood pressure	Yes ☐ No ☐	Migraine	Yes ☐ No ☐
Asthma	Yes ☐ No ☐	Dermatitis/Eczema	Yes ☐ No ☐
Emphysema	Yes ☐ No ☐	Yellow Jaundice (Hepatitis)	Yes ☐ No ☐
Varicose Veins	Yes ☐ No ☐	Tropical Disease (Ross River	Yes ☐ No ☐
Epilepsy	Yes ☐ No ☐	Virus, Malaria)	
Fainting or blackout episodes	Yes ☐ No ☐	Hormonal condition	Yes ☐ No ☐
Cancer or tumour	Yes ☐ No ☐	Allergies (Please list)	Yes ☐ No ☐

Examiner Comments: (Please comment on all YES answers)

SECTION 5: Occupational Health

Do you have OR have you ever had a work related disease or injury	Yes ☐ No ☐
Have you ever lodged a workers compensation claim? If yes; What was the claim for? Eg. Type of injury/illness:_____ What date was the claim lodged? _____ What date was the claim closed? _____ Did you return to normal duties? What treatment was required (eg. Surgery, physiotherapy etc)? _____	Yes ☐ No ☐ _____ _____ _____ Yes ☐ No ☐
In the last 6 months, have you lost time from work due to sickness/injury?	Yes ☐ No ☐
Have you ever had problems wearing gloves or other personal protective equipment?	Yes ☐ No ☐

Have you ever regularly been exposed to:

Chemicals	Yes ☐ No ☐	Radiation	Yes ☐ No ☐	Asbestos	Yes ☐ No ☐
Noise	Yes ☐ No ☐	Dust	Yes ☐ No ☐	Solvents	Yes ☐ No ☐
				Other	Yes ☐ No ☐

Examiner Comments: (Please comment on all YES answers)

SECTION 6: Musculoskeletal Health

Do you have OR have you ever had an injury or experienced pain/discomfort to any of the below areas?

Neck	Yes ☐ No ☐	Lower back	Yes ☐ No ☐
Shoulder	Yes ☐ No ☐	Hip	Yes ☐ No ☐
Elbow	Yes ☐ No ☐	Knee	Yes ☐ No ☐
Wrist or hand	Yes ☐ No ☐	Ankle or foot	Yes ☐ No ☐

Examiner Comments: (Please comment on all YES answers)

Do you have OR have you ever experienced any of the following symptoms?

Cervical (neck) aches & pains	Yes ☐ No ☐	Unexplained pins & needles	Yes ☐ No ☐
Lower back aches & pains	Yes ☐ No ☐	Unexplained muscle aches & pains	Yes ☐ No ☐
Sciatica (weakness/tingling in legs)	Yes ☐ No ☐	Unexplained joint aches & pains	Yes ☐ No ☐

Examiner Comments: (Please comment on all YES answers)

Do you have OR have you ever had any of the following conditions?

Repetitive strain injury (RSI)	Yes ☐ No ☐	Rheumatoid arthritis	Yes ☐ No ☐
Tennis elbow	Yes ☐ No ☐	Osteoporosis	Yes ☐ No ☐
Carpal Tunnel Syndrome	Yes ☐ No ☐	Fibromyalgia	Yes ☐ No ☐
Hernia	Yes ☐ No ☐	Broken/fractured bones	Yes ☐ No ☐
Osteoarthritis	Yes ☐ No ☐	Any other condition that affects your muscles, joints or bones	Yes ☐ No ☐

Examiner Comments: (Please comment on all YES answers)

SECTION 7: Cardiovascular Health

Do any of your direct family members have OR have ever had heart problems, such as high blood pressure, heart attack etc.?				Yes ☐	No ☐
Have you ever undergone chest or heart surgery?				Yes ☐	No ☐
Do you have or have you ever had any of the following conditions?					
Heart disease	Yes ☐	No ☐	Angina (chest pain)	Yes ☐	No ☐
Heart murmurs	Yes ☐	No ☐	High blood pressure	Yes ☐	No ☐
Palpitations or irregular heart beat	Yes ☐	No ☐	Pacemaker	Yes ☐	No ☐

Examiner Comments: (Please comment on all YES answers)

SECTION 8: Respiratory Health

Do you have or have you ever suffered from any of the following respiratory conditions?					
Wheezing asthma or exercise induced asthma	Yes ☐	No ☐	Tuberculosis	Yes ☐	No ☐
			Chronic obstructive	Yes ☐	No ☐
Emphysema	Yes ☐	No ☐	pulmonary disease	Yes ☐	No ☐
Hay fever	Yes ☐	No ☐	Rheumatic fever	Yes ☐	No ☐
			Bronchitis	Yes ☐	No ☐
Have you ever coughed up blood?				Yes ☐	No ☐
Have you ever experienced an unexplained shortness of breath?				Yes ☐	No ☐

Examiner Comments: (Please comment on all YES answers)

SECTION 9: Ear & Eye Health

Do you have a loss of hearing?	Yes ☐	No ☐
Do you have or have you ever had earaches, ear infections or discharge from your ear?	Yes ☐	No ☐
Do you or have you ever been required to use a hearing aid?	Yes ☐	No ☐
Do you have or have you ever had an eye injury or condition?	Yes ☐	No ☐
Do you wear glasses or contact lenses for either near or distance vision?	Yes ☐	No ☐
Are you colour blind?	Yes ☐	No ☐
Have you ever had surgery in relation to your eyes or ears? Eg. Laser eye surgery	Yes ☐	No ☐

Examiner Comments: (Please comment on all YES answers)

Patient Initials: _____

SECTION 10: Metabolic & Digestive Health		
Do you regularly suffer from indigestion or an upset stomach?	Yes ☐	No ☐
Have you ever passed or vomited blood?	Yes ☐	No ☐
Have you noticed any recent change in bowel habit?	Yes ☐	No ☐
Have you noticed a change in thirst and the number of times you urinate?	Yes ☐	No ☐
Have you started waking up at night to urinate?	Yes ☐	No ☐
Do you have trouble starting and stopping your urine flow?	Yes ☐	No ☐
Have you noticed a change in the strength of your urine flow?	Yes ☐	No ☐
Examiner Comments: (Please comment on all YES answers)		

SECTION 11: Mental Health				
Do you have or have you ever had a mental health issue requiring medication or counselling?			Yes ☐	No ☐
Have you ever been referred to a psychologist or psychiatrist?			Yes ☐	No ☐
Have you ever been prescribed antidepressants, sedatives, or sleeping tablets?			Yes ☐	No ☐
Have you ever had a problem with drug or alcohol abuse?			Yes ☐	No ☐
Do you have or have you ever had any of the following conditions?				
Depression	Yes ☐ No ☐	Insomnia	Yes ☐	No ☐
Panic attacks	Yes ☐ No ☐	Any other mental health condition	Yes ☐	No ☐
Anxiety	Yes ☐ No ☐			
Examiner Comments: (Please comment on all YES answers)				

SECTION 12: Fatigue & Heat Management		
Do you have or have you ever had a sleep disorder, such as sleep apnoea, or narcolepsy	Yes ☐	No ☐
Do you suffer from spells of complete exhaustion?	Yes ☐	No ☐
Have you ever had any problems with prolonged shift work?	Yes ☐	No ☐
Have you ever worked in a very hot environment?	Yes ☐	No ☐
Have you ever had an adverse reaction to working in a very hot environment?	Yes ☐	No ☐
Have you ever had a heat-related illness? (eg. heat stroke, heat exhaustion)	Yes ☐	No ☐
Have you ever had any treatment that reduces your capacity to sweat?	Yes ☐	No ☐
Do you have diabetes, thyroid problems or any other hormonal condition?	Yes ☐	No ☐
Do you have or have you ever had kidney stones, bladder stones or renal colic?	Yes ☐	No ☐
Examiner Comments: (Please comment on all YES answers)		

SECTION 13: Lifestyle	
On average, how many standard alcoholic drinks do you drink each day?	
What is the maximum number of standard alcoholic drinks you would drink in one day?	
Do you or have you ever smoked? If yes; ▪ How many cigarettes do or did you smoke per day?_____ ▪ If you have quit smoking, what date did you stop?_____	Yes ☐ No ☐
How many times per week do you normally exercise?	☐ 0 ☐ 1-2 ☐ 3-5 ☐ 5 or greater
What type of exercise do you regularly participate in? _____	
Do you have any concerns about any aspect of your health?	Yes ☐ No ☐
Examiner Comments: (Please comment on all YES answers)	

SECTION 14: Vaccination History	
Have you been vaccinated for the below? Tetanus Hep A/Hep B	 Yes ☐ No ☐ Yes ☐ No ☐
Examiner Comments: (Please comment on all YES answers)	

PLEASE TURN OVER

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Medical History

Release of Medical Information

I, ... DOB .....
(Print Name)

- Give full consent for all medical information, past and present - reported, presented to or held by REDiMED to be provided to authorised personnel of my prospective employer for the purpose of assessing my suitability for the position I have applied for.
- Understand that I will be tested for drugs as part of my Employment Medical Examination and that it is in my interests to reveal any prescription or non-prescription drugs (including vitamins) that I am taking.
- Declare that to the best of my knowledge the answers in this application are correct.
- Understand that if any false or deliberately misleading information is given, or any material facts withheld, I will not be accepted for employment, or if I am employed, my employment may be terminated.
- Authorise the examining doctor to release any information acquired from my medical history, examination and urine drug screen to authorised personnel of my prospective employer.

Signed: .....

Witness: .....

Date: .....

Patient Initials: _____