

SECTION 1: Personal Information

Surname		Given Name		DOB		M <input type="checkbox"/> F <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>

Examiner Comments: (Please comment on all YES answers)

SECTION 4: General Health					
Have you seen your doctor in the last 6 months concerning your health?				Yes <input type="checkbox"/>	No <input type="checkbox"/>
Has your weight altered much in the last 2 years?				Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you ever had any serious injuries, illness, mental or physical, which required medical treatment for a period of one week or more?				Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you ever spent time in hospital?				Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you ever had a blood transfusion?				Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have OR have you ever had any of the following?					
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Concussion or head injury	Yes <input type="checkbox"/>	No <input type="checkbox"/>
High blood pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Migraine	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Dermatitis/Eczema	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Emphysema	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yellow Jaundice (Hepatitis)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Varicose Veins	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Tropical Disease (Ross River)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Epilepsy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Virus, Malaria)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Fainting or blackout episodes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Hormonal condition	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cancer or tumour	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Allergies (Please list)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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 <input type="checkbox"/>	No <input type="checkbox"/>
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 <input type="checkbox"/>	No <input type="checkbox"/>
In the last 6 months, have you lost time from work due to sickness/injury?				Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you ever had problems wearing gloves or other personal protective equipment?				Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you ever regularly been exposed to:					
Chemicals	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Radiation	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Noise	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Dust	Yes <input type="checkbox"/>	No <input type="checkbox"/>
				Asbestos	Yes <input type="checkbox"/>
				Solvents	Yes <input type="checkbox"/>
				Other	Yes <input type="checkbox"/>
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 <input type="checkbox"/>	No <input type="checkbox"/>	Lower back	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Shoulder	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Hip	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Elbow	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Knee	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Wrist or hand	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Ankle or foot	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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 <input type="checkbox"/>	No <input type="checkbox"/>	Unexplained pins & needles	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Lower back aches & pains	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unexplained muscle aches & pains	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Sciatica (weakness/tingling in legs)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unexplained joint aches & pains	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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 <input type="checkbox"/>	No <input type="checkbox"/>	Rheumatoid arthritis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Tennis elbow	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Osteoporosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Carpal Tunnel Syndrome	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Fibromyalgia	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hernia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Broken/fractured bones	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Osteoarthritis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Any other condition that affects your muscles, joints or bones	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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 <input type="checkbox"/>	No <input type="checkbox"/>		
Have you ever undergone chest or heart surgery?		Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Do you have or have you ever had any of the following conditions?					
Heart disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Angina (chest pain)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart murmurs	Yes <input type="checkbox"/>	No <input type="checkbox"/>	High blood pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Palpitations or irregular heart beat	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Pacemaker	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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 <input type="checkbox"/>	No <input type="checkbox"/>	Tuberculosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Emphysema	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Chronic obstructive pulmonary disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hay fever	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Rheumatic fever	Yes <input type="checkbox"/>	No <input type="checkbox"/>
			Bronchitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you ever coughed up blood?				Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you ever experienced an unexplained shortness of breath?				Yes <input type="checkbox"/>	No <input type="checkbox"/>

Examiner Comments: (Please comment on all YES answers)

SECTION 9: Ear & Eye Health

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

Examiner Comments: (Please comment on all YES answers)

SECTION 10: Metabolic & Digestive Health

Do you regularly suffer from indigestion or an upset stomach?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you ever passed or vomited blood?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you noticed any recent change in bowel habit?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you noticed a change in thirst and the number of times you urinate?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you started waking up at night to urinate?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have trouble starting and stopping your urine flow?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you noticed a change in the strength of your urine flow?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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 <input type="checkbox"/>	No <input type="checkbox"/>
Have you ever been referred to a psychologist or psychiatrist?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you ever been prescribed antidepressants, sedatives, or sleeping tablets?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you ever had a problem with drug or alcohol abuse?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have or have you ever had any of the following conditions?		
Depression	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Panic attacks	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Anxiety	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Insomnia	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Any other mental health condition	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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 <input type="checkbox"/>	No <input type="checkbox"/>
Do you suffer from spells of complete exhaustion?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you ever had any problems with prolonged shift work?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you ever worked in a very hot environment?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you ever had an adverse reaction to working in a very hot environment?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you ever had a heat-related illness? (eg. heat stroke, heat exhaustion)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you ever had any treatment that reduces your capacity to sweat?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have diabetes, thyroid problems or any other hormonal condition?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have or have you ever had kidney stones, bladder stones or renal colic?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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; <ul style="list-style-type: none"> How many cigarettes do or did you smoke per day? _____ If you have quit smoking, what date did you stop? _____ 	Yes <input type="checkbox"/> No <input type="checkbox"/>
How many times per week do you normally exercise?	<input type="checkbox"/> 0 <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-5 <input type="checkbox"/> 5 or greater
What type of exercise do you regularly participate in? _____	
Do you have any concerns about any aspect of your health?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Examiner Comments: (Please comment on all YES answers)

SECTION 14: Vaccination History

Have you been vaccinated for the below?	
Tetanus	Yes <input type="checkbox"/> No <input type="checkbox"/>
Hep A/Hep B	Yes <input type="checkbox"/> No <input type="checkbox"/>
Examiner Comments: (Please comment on all YES answers)	

PLEASE TURN OVER

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.

☐ Physical Health
(Initials)

☐ Mental Health
(Initials)

- 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.

Signed:

Witness:

Date:

Declaration

I, DOB
(Print Name)

- 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: