

# MEDICAL HISTORY



## Personal Details: (to be filled in by Patient)

Surname: w

Given Names: q

Date of Birth: 08/09/1983

M ☒ F ☐

Phone Extension:

Home Address:

Home Phone:

Mobile Phone:

Next of Kin/Emergency Contact:

Relationship:

Contact No (AH):

Contact No (MH):

Address: As above ☒

Declaration:

I declare that the above information is true and correct, and that if any of this information changes, i will inform my company immediately and update these details.

Name: q w

Sign:

Date: 02/12/2014

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### Release of Medical Information

I, q w \_\_\_\_\_ DOB: 08/09/1983 \_\_\_\_\_

request to make available to the appropriate authorised management staff of my company, any details from my medical examination which may affect my suitability for the position which I have applied for.

I 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 drugs that I am taking

Signed:

Witness: dajdj \_\_\_\_\_

Date: 02/12/2014 \_\_\_\_\_

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### Declaration

I, q w \_\_\_\_\_ DOB: 08/09/1983 \_\_\_\_\_

Declare that to the best of my knowledge the answers in this application are correct and I understand that if any false or deliberately misleading information is given, or any material facts are withheld, I will not be accepted, or if I am employed, my employment may be terminated.

I authorise the examining doctor to release any information acquired from my medical history, examination and urine drug screen to the appropriate management staff of my company.

Signed:

Witness: dajdj \_\_\_\_\_

Date: 12/2/14 8:02 AM \_\_\_\_\_

Medical History/Questionnaire

(To be filled out prior to Doctors visit)

Please answer the following as fully as possible.

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## General Health Questions test

Question		YES	NO	Reason/Example/Date
1	Have you seen your doctor in the last 6 months concerning your health?	No		
2	Are you currently taking any medication? If yes, please state what medication.	No		
3	Do you have any allergies? What are your symptoms?	No		
4	Has your weight altered much in the last two years? How much?	No		
5	During a typical work day, how much water do you drink, ie cups, litres?	No		
6	Have you received a tetanus injection? What year?	No		
7	Have you received a Hepatitis A/B injection? What year?	No		
8	Do you usually have difficulties falling asleep or staying asleep?	No		
9	Have you noticed any abnormal bleeding from anywhere?	No		
10	Do you suffer from spells of complete exhaustion?	No		
11	Do you or have you ever suffered from fatigue?	No		
12	Have you ever had any serious injuries, illnesses, mental or physical, which required medical treatment for a period of one	No		
13	Do you consume alcohol on a regular basis? If yes:	No		
13.1	How many days per week?	No		
13.2	How many standard drinks on those days?	No		
14	14. Are you a smoker? If yes:	No		
14.1	How many cigarettes do you smoke a day (no. of cigarettes)?	No		
14.2	Tailor made or roll-your-own?	No		
14.3	How old were you when you started smoking?	No		
14.4	Have you ever smoked?	No		
14.5	When did you start and stop?	No		
14.6	How many cigarettes did you smoke a day?	No		
15	Do you exercise regularly? How often and what type of exercise?	No		
16	Do you have any concerns about any aspect of your health?	No		

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### Workers' Compensation / Work related Questions

Question		YES	NO
1	Do you or have you had a work related disease or injury?	No	
2	Have you ever lodged or do you have a worker's compensation claim?	No	
3	In the last 6 months, have you lost time from work due to sickness?	No	
4	Do you have any health issues that restrict you from completing your work?	No	
5	Have you ever had problems wearing gloves or other personal protective equipment?	No	
6	6. Have you ever been regularly exposed to:	No	
6.1	Chemicals	No	
6.2	Noise	No	
6.3	Asbestos	No	
6.4	Solvents	No	
6.5	Radiation	No	
6.6	Dust	No	
6.7	Other	No	

### Questions concerning Musculoskeletal Problems

Question		YES	NO
1	Have you ever:	No	
1.1	Spent time in hospital?	No	
1.2	Had a blood transfusion?	No	
1.3	Broken or fractured any bones?	No	
1.4	Had any other injury not related to work, ie from an accident,	No	
2	Have you ever had a cervical (neck) injury?	No	
3	Have you ever suffered a lumbar (lower back) injury?	No	
4	Do you have any pain and/or stiffness in:	No	
4.1	Cervical (neck) spine	No	

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5	Have you ever had any injury or condition to your:	No	
5.1	Shoulder	No	
5.2	Elbow	No	
5.3	Wrist	No	
5.4	Hip	No	
5.5	Knee	No	
5.6	Ankle	No	
6	Do you or have you ever suffered from Repetitive Strain Injury (RSI), Occupational Overuse Syndrome, Tennis Elbow,	No	
7	Do you ever experience unexplained pins and needles in your hands?	No	
8	Do you suffer from Arthritis (ie Rheumatoid arthritis, Osteoarthritis) or Osteoporosis?	No	
9	Have you ever or do you have aches and pains in your muscles that are not related to exercise, ie fibromyalgia?	No	
10	Have you ever or do you suffer from foot trouble or difficulty wearing shoes?	No	

### Questions concerning Respiratory and Cardiovascular Health

Question		YES	NO	
1	Do any of your immediate family members suffer, or have suffered from, heart problems ie high blood pressure, heart	No		
2	Have you ever or do you suffer from Angina (Chest pain)?	No		
3	Have you ever undergone chest or heart surgery?	No		
4	Have you ever or do you suffer from:	No		
4.1	Heart Disease	No		
4.2	Palpitations or Irregular Heart Beat	No		
4.3	Heart Murmurs	No		
4.4	High Blood Pressure	No		
5	Have you ever had or suffer from a chronic chest condition such as:	No		
5.1	Wheezing Asthma or Exercise Induced Asthma	No		
5.2	Emphysema	No		
5.3	Bronchitis	No		

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5.4	Tuberculosis	No	
5.5	Hay Fever	No	
5.6	Chronic Obstructive Pulmonary Disease	No	
5.7	Rheumatic Fever	No	
6	Have you ever coughed up blood?	No	

### Questions concerning Head, Ear, Eye and Skin Health

Question		YES	NO	
1	Have you ever had a head injury or a concussion?	No		
2	Have you ever or do you suffer from frequent headaches or migraines?	No		
3	Have you ever or do you suffer from fits, Epilepsy?	No		
4	Have you ever or do you suffer from blackouts or fainting episodes?	No		
5	Do you suffer from loss of hearing?	No		
6	Have you ever or do you suffer earaches, ear infections or discharge from your ear?	No		
7	Have you ever or do you suffer from eye trouble ie. Eye injury, lazy eye, loss of vision due to an injury or glaucoma?	No		
8	Are you colour blind?	No		
9	Do you wear glasses or contact lenses? Please state for near or distance vision.	No		
10	Have you ever or do you suffer from Dermatitis/eczema?	No		

### Questions concerning Stomach, Metabolic Health and other

Question		YES	NO	
1	Have you ever suffered a hernia?	No		
2	Do you suffer from indigestion or upset stomach?	No		
3	Have you ever or do you suffer from passing blood or vomiting blood?	No		
4	Have you noticed any recent changes in bowel habit?	No		
5	Have you noticed a change in thirst and the number of times you urinate?	No		
6	Have you started waking up at night to urinate?	No		
7	Do you have trouble starting and stopping your urine flow?	No		

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8	Have you noticed a change in the strength of your urine flow?	No	
9	Have you ever or do you suffer from Diabetes?	No	
10	Are you an insulin dependent Diabetic?	No	
11	Have you ever or do you suffer from Yellow Jaundice (hepatitis)?	No	
12	Have you ever or do you suffer from Malaria, Dengue Fever, Rossriver Virus or any other tropical disease?	No	

### Statement

Section 79 of the Western Australian Workers' Compensation and Injury Management Act 1981 gives an arbitrator discretion to refuse to award compensation which would otherwise be payable 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.

I have read the above statements. The answers are correct, and no information concerning my present or past health has been withheld

Signed:

Date: 02/12/2014

Name: q null w

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