

PRE-EMPLOYMENT HEALTH ASSESSMENT QUESTIONNAIRE

Personal Details

Family Name: phuong

Date of Birth: 01/01/0001

Proposed Occupation: we

Specific work location: eeexasc

Best Contact phone numbers (with message ew

Job Number: _____

Given Names: nguyen 2

Gender: Male

Job Location: ew

APPLICANTS

This pre-employment medical assessment involves completing a health questionnaire and having a general medical examination. It MAY (depending on the job) involve a chest X-ray, blood tests, MRI, urine drug screen, alcohol breath test, audiometry (hearing test), spirometry (lung test), manual handling assessment, fitness test and/or ECG.

The Pre-Employment Health Assessment is part of the employment process and is used to assess your suitability for the position and the physical work environment for which you are being considered; and to ensure you are not at increased risk of injury to yourself and/or other employees in this position. This examination is NOT to treat health issues that are concerning you - you should see your GP for this. It also cannot be used for any other job you might be applying for. The assessment may take up to 90 minutes. Please complete the questionnaire and hand to the receptionist.

- Complete section 1 by answering YES or EVERY question (mark the YES or NO box clearly)
- Initial the bottom right corner of each page
- Read the declaration and sign

Questionnaire (Answer every question)

Q1 - About your work

Year		Job	Employer
From	To		
06/06/2014	06/06/201	job 1	hhh
06/06/201	06/06/201	job 2	jkj

Is the Job you are applying for now the same TYPE of WORK you are now doing? N ☐ Y ☒

If No, have you ever done this work in the past? N ☒ Y ☐

Some WORK ENVIRONMENTS are challenging - they may be hot, humid, dusty, remote, or involve working with specific chemicals and fumes e.g. Sulphur Dioxide, Nickel, Grain Dust. These environments MAY affect or be affected by some specific health conditions.

Have you previously worked in the same WORK ENVIRONMENT as this job? N ☒ Y ☐

If YES, did you have any problems? N ☒ Y ☐

Are you aware of anything which would cause problems for you working in this N ☒ Y ☐

Are you aware of anything which would prevent you working in the following (Answer every

Underground N ☒ Y ☐ In wet N ☒ Y ☐

Dusty conditions, Grain dust N ☒ Y ☐ With Nickel N ☒ Y ☐

Remote N ☒ Y ☐ Very hot, humid conditions N ☒ Y ☐

At N ☒ Y ☐

Is the job you are applying for fly in fly out	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
If Yes, have you done FIFO before?	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
If Yes, Did you have any problems?	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Is the job you are applying for shift work?	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
If Yes, have you done shift work before?	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
If Yes, Did you have any problems especially with fatigue?	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Are you fully able and prepared to wear/use all required safety (This might include - Hard hat, safety glasses, safety boots, gloves, respirator, mask, ear muffs or plugs, a harness or any other safety equipment that might be required)	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>

Examiners Comments to yes answers

sqws

Q2 - About your general

Have you ever had an operation, procedure or surgery or been admitted to	N <input type="checkbox"/>	Y <input checked="" type="checkbox"/>
Have you ever had a motor vehicle (inc. motor bike) accident which caused you	N <input type="checkbox"/>	Y <input checked="" type="checkbox"/>
Have you ever had a sports injury (apart from minor sprains)?	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
If YES When? sqws		
Did you need time off	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
How long were you on modified or light	How long were you	
How long did you need		
Did you return to normal duties?	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Was there a compensation payout?	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Were there any associated psychological	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>

Examiners Comments to yes answers

Do you have any dental health problems or dental work	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Are you an Insulin dependent	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Have you ever had a seizure?	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Are you Epileptic?	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Are you asthmatic?	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Do you have any	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Do you wear a Medic Alert bracelet?	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>

Do you currently have OR have you EVER had any of the (Answer every

Q3 -

(Musculoskeletal Health refers to tendons, muscles, ligaments, bones, joints and spine discs)

Neck injury, or	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>	Arm or wrist injury	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
A disk injury in the back or	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>	Hand injury	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Frequent backache	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>	Leg injury	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Physio/Chiropractic	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>	Knee cartilage surgery	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Back injury	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>	Knee reconstruction	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Sciatica	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>	Foot problems	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Back or neck surgery	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>	Any other bone or joint	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Swollen joints	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>	Rheumatism/arthritis	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Arthritic knee or	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>			
RSI, wrist strain, overuse syndrome or carpal tunnel	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>			
Hernia (groin)	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>			

Q4 - Mental

Have you ever had any mental health issue requiring medication (antidepressants, sedatives or sleeping tablets) or counselling?	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Have you ever been referred to a psychologist or	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Have you ever had a problem with drugs or	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Depression	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Panic attacks	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Other nervous	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Anxiety	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Insomnia	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>

Q5 - Skin health:

Eczema	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>	Dermatitis	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Psoriasis	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>	Skin cancers	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Any other skin	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>			

Q6 - Respiratory (lung) and cardiovascular

Asthma	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>	Emphysema	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Industrial lung disease	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>	Heart disease	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Artery or vein	N <input type="checkbox"/>	Y <input type="checkbox"/>	Bronchitis	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
High blood pressure	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>	Collapsed lung (pneumothorax)?	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
DVT (Thrombosis)	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>	Heart attack	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Have you ever used a puffer?	N <input type="checkbox"/>	Y <input type="checkbox"/>			
Do you have a cardiac	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>			

Q7 - Neurological

Head injury/concussion	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>	Severe headaches/migraines	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Epilepsy/fits/Vertigo	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>	Any other neurological	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>

Q8 - Miscellaneous

Diabetes on Insulin	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>	Arthritis	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Diabetes on Medication	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>	Blood disorder	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Diabetes on Diet control	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>	Cancer or tumour	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Kidney problems	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>	Bowel problems	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Liver	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>	Hepatitis	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
A hearing loss	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>	A problem with vision	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Heat exhaustion/heat stroke	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>	Any other chronic illness	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>

Q9 - Women's health:

Are you pregnant	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>	Are you Breast feeding	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
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Examiners Comments to yes answers

Occupational

Q10 - Do you have any disabilities or difficulties that may place you at increased risk at work? N ☒ Y ☐

Q11 - Are you freely able

Climb (ladders, stairs etc)	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>	Squat frequently	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Bend and lift	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>	Push, pull and reach	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Work overhead	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>	Work underground	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Work at heights	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>	Work in dusty conditions	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Work in isolation	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>	Work in confined spaces	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Read instruments	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>	Work over uneven ground	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Work in awkward postures	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>	Work with vibration	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>

Q12 - Do you have any of the following disabilities or

Loss of full back function	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>	Loss of full arm	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Loss of full leg function	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>	Psychological problems	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Difficulty hearing/need a hearing	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>	Breathing problems	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Loss of eye/loss of vision in eye	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>	Chronic skin problems	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Glasses for reading/distance	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>	Alcohol or drug misuse	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Othe Loss of function	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>	Loss of mobility	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Loss of full movements	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>	Loss of full neck function	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Any other problem	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>			

Examiners Comments to yes answers

Q13 - Have you ever: (Answer every

Been medically advised to change N ☒ Y ☐
 Been medically advised to limit or restrict N ☒ Y ☐
 Had more than 1 week off because of injury N ☒ Y ☐

If Yes to above question, what was this

Have you ever needed to be Medi-vac'd from an offshore facility or remote site? N ☒ Y ☐

Details:

Examiners Comments to yes answers

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Q14 - Have you ever suffered any work-related disease, or claimed workers N ☒ Y ☐

If YES what year and what was it

How long were you off

How long were you on modified or light

How long did you need

Did you return to normal N ☒ Y ☐

Was there a compensation payout? N ☒ Y ☐

Were there any associated psychological N ☒ Y ☐

Details:

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Do you have a current open W/C claim? N ☒ Y ☐

Examiners Comments to yes answers

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Q15 - Do you take any medications including inhalers and patches? N ☒ Y ☐

List:

Q16 - Allergies: (Answer Every

I get hay fever N ☒ Y ☐ I get asthma N ☒ Y ☐

I get eczema/dermatitis N ☒ Y ☐

I am allergic

I have needed adrenaline in the past for a serious allergy N ☒ Y ☐

I carry Adrenalin (Epipen) N ☒ Y ☐

Q17 - Regarding Immunisations. Have you had: (Answer every

Q Fever or the immunisation	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>	Tetanus immunisation	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Hepatitis A or the	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>	Hepatitis B or the	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>

Examiners Comments to yes answers

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Q18 - About your respiratory (lung)

In the past 3 years have you had a period of increased cough and phlegm lasting three weeks or	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Have you had any chest illness which has kept you from your usual activities for a week or	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Do you get short of breath when hurrying on level ground or walking up a slight	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Do you get short of breath when walking with other people of your age on level	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Do you ever wake up in your sleep short of breath?	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Does your chest ever sound wheezy or whistling?	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Does your chest ever feel tight or your breathing become	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
Have you ever been given or used a puffer?	N <input checked="" type="checkbox"/>	Y <input type="checkbox"/>
If YES, When was the last time you used a puffer?	

Q19 - Smoking

Do or did you smoke more than 1 cigarette/day; a cigar/week; or 2 oz pipe tobacco/month? N ☒ Y ☐

If NO go to question 20 below. If YES continue

How much do you smoke? cigarettes / cigars per0.....or roll your own or pipes0.....

How many years have you or did you smoke0.....

Q20 - Alcohol

How many drink/s would you drink on average per

What is the maximum number of drinks you'd drink in one

(A standard drink = 285 ml of beer, a nip of spirits or a glass of

Q21 - Your exercise

How often would you exercise for 20 minutes or

Rarely/occasionally/never ☐ once or twice a ☐ three or more times per ☐

Do you play any sport or do gym regularly? N ☒ Y ☐

If YES,

football <input type="checkbox"/>	golf <input type="checkbox"/>	tennis <input type="checkbox"/>
squash- <input type="checkbox"/>	bowls- <input type="checkbox"/>	<input type="checkbox"/>
other <input type="checkbox"/>	

Q22 - Fatigue &

Have you ever had, or been told by a doctor that you had a sleep disorder, sleep apnoea, or
Has anyone noticed that your breathing stops or is disrupted by episodes of choking during your
Do you use a CPAP breathing device at

N ☒ Y ☐
N ☒ Y ☐
N ☒ Y ☐

Q23 - Epworth Sleepiness

How likely are you doze off or fall in the following situations, in contrast to just feeling

Chance of dozing (0-

0 = would never doze 2 = moderate chance of
1 = slight chance of dozing 3 = high chance of dozing

Write the appropriate number in the

Sitting and reading	0
Watching TV	0
Sitting, inactive in a public place (e.g. A theatre or	0
As a passenger in a car for an hour without a	0
Lying down to rest in the afternoon when	0
Sitting and talking to	0
Sitting quietly after a lunch without	0
In a car, while stopped for a few minutes in the	0
TOTAL SCORE	0.0

APPLICANT AUTHORISATION AND DECLARATION

I consent to a medical examination, urine drug test, a chest x-ray an MRI or an ECG, in relation to my application for

I declare that the information which I have set out in this questionnaire is truthful and that there are no misleading answers or omissions. I understand that if I am employed and it is subsequently established that I have been misleading or untruthful, I may be terminated from employment.

I understand that employers may be able to reject compensation if it is found that I have been false or misleading.

I authorise a medical representative to contact any person, clinic or hospital, which has previously provided me with treatment in order to obtain further medical information which may assist them or my prospective employer in determining my suitability for the job for which I have applied.

I authorise the medical representative to release details of my personal medical details from this pre-employment medical to the authorised representative at my prospective employment. All medical details shall remain strictly confidential and for use only by the authorised representative in the interests of my safety and well being whilst I am an employee.

Signature

Date

EXTERNAL EXAMINERS:

- Please give details on all positive questionnaire responses.
 - o If there is no comment we are unsure whether the questionnaire response has been
- Please ensure your staff have completed a satisfactory spirometry.
 - o Asthma is a very important condition in relation to many jobs with potential exposure to irritants - it is vital we have accurate spirometry results. The following web link to a Spirometry that may be of value to yourself and your staff (www.jobfit.com.au).
not enter percentages of predicted values - enter actual
- If a urine drug screen is sent to a laboratory please ensure that the request form is copy of the result to be sent direct to preferred medical service
 - o This prevents delays and expedites the applicant's opportunity to be employed.
- Do not perform any tests that are not on the purchase order.
 - o We will not take responsibility for unauthorised charges. This examination is not to investigate any health issues.
- It is important we know what work the applicant is currently doing and/or has done significant health issue or
 - o Many jobs involve difficult work in difficult environments e.g. hot, humid, underground, fly in fly out etc - the applicant's experience of these types of work may be
- Please refrain from making or suggesting a determination regarding suitability for
 - o It is the responsibility of the Occupational Physicians to make the determination re and to advise about risk profile. We need comprehensive information from you to do
- Please ensure all requested parts of the health assessment are completed.