

PRE-EMPLOYMENT HEALTH ASSESSMENT

Examiner: * Check that the questionnaire has been completed correctly.
* Check that an explanation has been given for **every** positive response.
* Add any further comments to this form.

Family Name q Given Names w

Photo – ID has been sighted (compulsory) Confirmed ☐ Not sighted ☒

Hand Dominance Right ☒ Left ☐

Height 12 cms Weight 34 kgs

Urinalysis

Instant Drug Screen

| | | | | | | -ve | +ve | | -ve | +ve | | | | |
|------------|------------------------------|---|---|--------------------------|----|--------------------------|-----|--------------------------|----------|--------------------------|-------------------------------------|-------------------------------------|-------------------------------------|--------------------------|
| Protein | Nil <input type="checkbox"/> | Trace <input checked="" type="checkbox"/> | + | <input type="checkbox"/> | ++ | <input type="checkbox"/> | +++ | <input type="checkbox"/> | Cannabis | <input type="checkbox"/> | <input checked="" type="checkbox"/> | Benzo's | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Comment: 1 | | | | | | | | | | | | | | |
| Glucose | Nil <input type="checkbox"/> | Trace <input checked="" type="checkbox"/> | + | <input type="checkbox"/> | ++ | <input type="checkbox"/> | +++ | <input type="checkbox"/> | Opiates | <input type="checkbox"/> | <input checked="" type="checkbox"/> | Cocain | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Comment: 2 | | | | | | | | | | | | | | |
| Blood | Nil <input type="checkbox"/> | Trace <input checked="" type="checkbox"/> | + | <input type="checkbox"/> | ++ | <input type="checkbox"/> | +++ | <input type="checkbox"/> | Amphet's | <input type="checkbox"/> | <input checked="" type="checkbox"/> | Methamph | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Comment: 3 | | | | | | | | | | | | | | |
| | | | | | | | | | | Alcohol | <input type="checkbox"/> | <input checked="" type="checkbox"/> | | |

Audiogram (please complete OR ☐ attach audio readout)

| | 500Hz | 1000Hz | 1500Hz | 2000Hz | 3000Hz | 4000Hz | 6000Hz | 8000Hz |
|-----------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|
| Right Ear | <input type="text" value="1"/> | <input type="text" value="3"/> | <input type="text" value="5"/> | <input type="text" value="7"/> | <input type="text" value="9"/> | <input type="text" value="1"/> | <input type="text" value="2"/> | <input type="text" value="3"/> |
| Left Ear | <input type="text" value="2"/> | <input type="text" value="4"/> | <input type="text" value="6"/> | <input type="text" value="8"/> | <input type="text" value="9"/> | <input type="text" value="2"/> | <input type="text" value="1"/> | <input type="text" value="4"/> |

Spirometry (please complete OR ☐ attach spiro readout - use actual values not %)

| | FEV1 | FVC | PERFR | | | | |
|---|---------------------------------------|---------------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|
| Pre-Br/dilator | <input type="text" value="1"/> | <input type="text" value="2"/> | <input type="text" value="3"/> | <input type="text" value="4"/> | <input type="text" value="5"/> | <input type="text" value="6"/> | <input type="text" value="7"/> |
| Pre-Br/dilator | <input type="text" value="8"/> | <input type="text" value="9"/> | <input type="text" value="1"/> | <input type="text" value="2"/> | <input type="text" value="3"/> | <input type="text" value="4"/> | <input type="text" value="5"/> |
| Is Spirometry satisfactory? | Y <input type="checkbox"/> | N <input checked="" type="checkbox"/> | | | | | |
| Candidate ever used a puffer? | Y <input checked="" type="checkbox"/> | N <input type="checkbox"/> | | | | | |
| If Yes to either of above, was there any respiratory problem? | Y <input checked="" type="checkbox"/> | N <input type="checkbox"/> | | | | | |

Examiners Comments

S

Vision

| | | | | | | |
|---------------------|--------------|---|-------------------------------------|------------|----------------|----------------|
| Visual Acuity: | Uncorrected: | L | R | Corrected: | L | R |
| | | <div>6/2</div> | <div>6/3</div> | | <div>6/4</div> | <div>6/5</div> |
| Near Vision: | | <div>N6</div> | <div>N7</div> | | <div>N82</div> | <div>N9</div> |
| Visual Fields: | | Left | Right | | | |
| | Normal | <input type="checkbox"/> | <input checked="" type="checkbox"/> | | | |
| | <45° | <input checked="" type="checkbox"/> | <input type="checkbox"/> | | | |
| Ishihara responses: | Number wrong | <div>12</div> (ONLY IF APPLICABLE TO JOB) | | | | |

Cardiovascular

| | | | | |
|---------------|--|--|--|---|
| Systolic BP | Diastolic BP | | Pulse | |
| Heart Rhythm: | Normal <input type="checkbox"/> | AF <input checked="" type="checkbox"/> | Occ. Ectopics <input type="checkbox"/> | Freq. Ectopics <input type="checkbox"/> |
| Heart Sounds: | Normal <input checked="" type="checkbox"/> | Abnormal <input type="checkbox"/> | | |
| Pacemaker: | Y <input type="checkbox"/> | N <input checked="" type="checkbox"/> | | |

Respiratory

| | | | | | |
|---------------|---|--|--|---------------------------------|------------------------------|
| Chest: | Normal <input type="checkbox"/> | Reduced (<5cm) <input checked="" type="checkbox"/> | | | |
| Air Entry: | Upper Zones | Normal <input checked="" type="checkbox"/> Reduced (<5cm) <input type="checkbox"/> | | | |
| | Lower Zones | Normal <input type="checkbox"/> Reduced (<5cm) <input checked="" type="checkbox"/> | | | |
| Added Sounds: | Nil <input checked="" type="checkbox"/> | Widespread crackles <input type="checkbox"/> | Basal crackles <input checked="" type="checkbox"/> | Wheeze <input type="checkbox"/> | Rub <input type="checkbox"/> |

Ears

| | | | | | |
|---------------------|--|--|---|--|------------------------------|
| External Canals: | Normal <input type="checkbox"/> | Dermatitis <input checked="" type="checkbox"/> | Fungal infection <input type="checkbox"/> | Structural abnormality <input checked="" type="checkbox"/> | Wax <input type="checkbox"/> |
| Tympanic Membranes: | Normal <input checked="" type="checkbox"/> | Effusion <input type="checkbox"/> | Wet perforation <input checked="" type="checkbox"/> | Dry perforation <input type="checkbox"/> | |

Skin

| | | | | |
|-------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| External Canals: | <u>Nil</u> | <u>Mild</u> | <u>Moderate</u> | <u>Severe</u> |
| Eczema/dermatitis | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Psoriasis | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tinea | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Solar damage | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Folliculitis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Other | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

| Examiners Comments | | | | | | | | | |
|----------------------|--|--|---|---|---|--|--|--|--|
| 4 | | | | | | | | | |
| Abdomen | | | | | | | | | |
| Scars: | Nil <input checked="" type="checkbox"/> | Appendix <input checked="" type="checkbox"/> | Gallbladder <input checked="" type="checkbox"/> | Hernia <input checked="" type="checkbox"/> | Other <input checked="" type="checkbox"/> | | | | |
| Hernial orifices: | Normal <input checked="" type="checkbox"/> | Inguinal hernia <input type="checkbox"/> | R <input checked="" type="checkbox"/> | L <input checked="" type="checkbox"/> | | | | | |
| Rectus muscles: | Normal <input type="checkbox"/> | Weak/bulging <input checked="" type="checkbox"/> | | | | | | | |
| CNS | | | | | | | | | |
| Muscle tone: | Normal <input type="checkbox"/> | Reduced <input checked="" type="checkbox"/> | | | | | | | |
| Muscle power: | Normal <input checked="" type="checkbox"/> | Reduced <input type="checkbox"/> | | | | | | | |
| Muscle wasting: | Nil <input type="checkbox"/> | Present <input checked="" type="checkbox"/> | | | | | | | |
| Tremor: | Nil <input checked="" type="checkbox"/> | Resting <input type="checkbox"/> | | | | | | | |
| Gait: | Normal <input type="checkbox"/> | Reduced <input checked="" type="checkbox"/> | | | | | | | |
| Lower limb reflexes: | Normal <input checked="" type="checkbox"/> | Left Reduced <input type="checkbox"/> | Normal <input type="checkbox"/> | Right Reduced <input checked="" type="checkbox"/> | | | | | |
| Detail <u>erwer</u> | | | | | | | | | |
| | | | | | | | | | |
| Neck Function | | | | | | | | | |
| Posture: | Normal <input type="checkbox"/> | Scoliosis <input checked="" type="checkbox"/> | | | | | | | |
| Rhythm: | Normal <input checked="" type="checkbox"/> | Jerky/painful <input type="checkbox"/> | | | | | | | |
| Flexion: | Normal <input type="checkbox"/> | >75% <input checked="" type="checkbox"/> | 50-75% <input type="checkbox"/> | 25-50% <input type="checkbox"/> | <25% <input type="checkbox"/> | | | | |
| Extension: | Normal <input type="checkbox"/> | >75% <input type="checkbox"/> | 50-75% <input checked="" type="checkbox"/> | 25-50% <input type="checkbox"/> | <25% <input type="checkbox"/> | | | | |
| Lateral flexion: | Normal <input type="checkbox"/> | >75% <input type="checkbox"/> | 50-75% <input type="checkbox"/> | 25-50% <input checked="" type="checkbox"/> | <25% <input type="checkbox"/> | | | | |
| Rotation: | Normal <input type="checkbox"/> | >75% <input type="checkbox"/> | 50-75% <input checked="" type="checkbox"/> | 25-50% <input type="checkbox"/> | <25% <input type="checkbox"/> | | | | |
| Back Function | | | | | | | | | |
| Posture: | Normal <input type="checkbox"/> | Scoliosis <input type="checkbox"/> | Kyphosis <input checked="" type="checkbox"/> | | | | | | |
| Rhythm: | Normal <input checked="" type="checkbox"/> | Jerky/painful <input type="checkbox"/> | | | | | | | |
| Flexion: | Normal <input type="checkbox"/> | >75% <input checked="" type="checkbox"/> | 50-75% <input type="checkbox"/> | 25-50% <input type="checkbox"/> | <25% <input type="checkbox"/> | | | | |
| Extension: | Normal <input type="checkbox"/> | >75% <input type="checkbox"/> | 50-75% <input checked="" type="checkbox"/> | 25-50% <input type="checkbox"/> | <25% <input type="checkbox"/> | | | | |
| Lateral flexion: | Normal <input type="checkbox"/> | >75% <input type="checkbox"/> | 50-75% <input type="checkbox"/> | 25-50% <input checked="" type="checkbox"/> | <25% <input type="checkbox"/> | | | | |
| Rotation: | Normal <input type="checkbox"/> | >75% <input type="checkbox"/> | 50-75% <input checked="" type="checkbox"/> | 25-50% <input type="checkbox"/> | <25% <input type="checkbox"/> | | | | |

Examiners Comments

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Limb Function

| | | | | | | |
|------------|-------------------------------------|-------------------------------------|-------------------------------|---------------|-------------------------------------|-------------------------------------|
| Mobility: | <u>Normal</u> | <u>Reduced</u> | <u>Painful</u> | | <u>Normal</u> | <u>Abnormal</u> |
| Shoulder | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Grip Strength | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Elbows | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Epicondyles | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Wrists | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Knees | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Ankles | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| | <u>Normal</u> | <u>Abnormal</u> | | | <u>Normal</u> | <u>Abnormal</u> |
| Heel walk: | <input type="checkbox"/> | <input checked="" type="checkbox"/> | | Rhomberg's | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Duck walk: | <input checked="" type="checkbox"/> | <input type="checkbox"/> | (walk in HALF squat position) | | | |
| Toe walk: | <input type="checkbox"/> | <input checked="" type="checkbox"/> | | | | |

Any Further Comments on Questionnaire

6

Comments on Examination

7

Examiner's Name/Stamp

q

SIGNATURE



Signature

11/11/2014

Date