

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 Nguyen Given Names Luan

Photo – ID has been sighted (compulsory) Confirmed Not sighted
Hand Dominance Right ☐ Left ☐

Height 12 cms Weight kgs

Urinalysis

Instant Drug Screen

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

Audiogram (please complete OR ☐ attach audio readout)

	500Hz	1000Hz	1500Hz	2000Hz	3000Hz	4000Hz	6000Hz	8000Hz
Right Ear								
Left Ear								

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

	FEV1	FVC	PERFR
Pre-Br/dilator			
Pre-Br/dilator			
Is Spirometry satisfactory?	Y <input type="checkbox"/> N <input type="checkbox"/>		
Candidate ever used a puffer?	Y <input type="checkbox"/> N <input type="checkbox"/>		
If Yes to either of above, was there any respiratory problem?	Y <input type="checkbox"/> N <input type="checkbox"/>		

Examiners Comments

Vision

Visual Acuity: Uncorrected: L R Corrected: L R

 6/ 6/ 6/ 6/

Near Vision: N N N N

Visual Fields: Left Right

 Normal ☐ ☐

 <45° ☐ ☐

Ishihara responses: Number wrong (ONLY IF APPLICABLE TO JOB)

Cardiovascular

Systolic BP Diastolic BP Pulse

Heart Rhythm: Normal ☐ AF ☐ Occ. Ectopics ☐ Freq. Ectopics ☐

Heart Sounds: Normal ☐ Abnormal ☐

Pacemaker: Y ☐ N ☐

Respiratory

Chest: Normal ☐ Reduced (<5cm) ☐

Air Entry: Upper Zones Normal ☐ Reduced (<5cm) ☐

 Lower Zones Normal ☐ Reduced (<5cm) ☐

Added Sounds: Nil ☐ Widespread crackles ☐ Basal crackles ☐ Wheeze ☐ Rub ☐

Ears

External Canals: Normal ☐ Dermatitis ☐ Fungal infection ☐ Structural abnormality ☐ Wax ☐

Tympanic Membranes: Normal ☐ Effusion ☐ Wet perforation ☐ Dry perforation ☐

Skin

External Canals: Nil Mild Moderate Severe

Eczema/dermatitis ☐ ☐ ☐ ☐

Psoriasis ☐ ☐ ☐ ☐

Tinea ☐ ☐ ☐ ☐

Solar damage ☐ ☐ ☐ ☐

Folliculitis ☐ ☐ ☐ ☐

Other ☐ ☐ ☐ ☐

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

Examiners Comments

Limb Function

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

Any Further Comments on Questionnaire

Comments on Examination

sd

Examiner's Name/Stamp
Nguyen

SIGNATURE

Signature

Date _____