

## 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 11 Given Names 11

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

Height 123 cms Weight 44 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    1      Diastolic BP    2      Pulse    3

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

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 Reduced <input type="checkbox"/>	Normal <input type="checkbox"/>	Right 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

gdf

Examiner's Name/Stamp

11

SIGNATURE



Signature

Date