

## 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 hihi Given Names hi

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

Height 180 cms Weight 80 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"/>						
Comment:						Cannabis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Benzo's	<input type="checkbox"/>	<input type="checkbox"/>
Glucose	Nil <input type="checkbox"/>	Trace <input checked="" 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 checked="" type="checkbox"/>	++ <input type="checkbox"/>	+++ <input type="checkbox"/>	Alcohol	<input type="checkbox"/>	<input type="checkbox"/>			
Comment: More test											

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 checked="" type="checkbox"/>	N <input 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

No.....  
.....  
.....  
.....  
.....

## 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:	<u>Nil</u>	<u>Mild</u>	<u>Moderate</u>	<u>Severe</u>
Eczema/dermatitis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input checked="" type="checkbox"/>	<input 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 checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

### Examiners Comments

### 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 checked="" type="checkbox"/>	<input type="checkbox"/>
Elbows	<input checked="" 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 checked="" 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 checked="" type="checkbox"/>	<input 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 checked="" type="checkbox"/>	<input type="checkbox"/>				

### Any Further Comments on Questionnaire

### Comments on Examination

Examiner's Name/Stamp

SIGNATURE

Signature

Date