

## 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

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

Audiogram (please complete OR ☐ attach audio readout)

	500Hz	1000Hz	1500Hz	2000Hz	3000Hz	4000Hz	6000Hz	8000Hz
Right Ear	1	3	5	7	9	1	2	3
Left Ear	2	4	6	8	9	2	1	4

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

	FEV1	FVC	PERFR				
Pre-Br/dilator	1	2	3	4	5	6	7
Pre-Br/dilator	8	9	1	2	3	4	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

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Vision										
Visual Acuity:	Uncorrected:	L	R	Corrected:	L	R				
		6/ 2	6/ 3		6/ 4	6/ 5				
Near Vision:		N 6	N 7		N 8	N 9				
Visual Fields:	Left	Right								
	Normal	<input type="checkbox"/>	<input checked="" type="checkbox"/>							
	<45°	<input checked="" type="checkbox"/>	<input type="checkbox"/>							
Ishihara responses:	Number wrong	124	(ONLY IF APPLICABLE TO JOB)							
Cardiovascular										
Systolic BP	1	Diastolic BP	2	Pulse	3					
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 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 type="checkbox"/>	Wax	<input type="checkbox"/>
Tympanic Membranes:	Normal	<input type="checkbox"/>	Effusion	<input checked="" type="checkbox"/>	Wet perforation	<input 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 checked="" type="checkbox"/>	Grip Strength	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Elbows	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Epicondyles	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Wrists	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Knees	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			
Ankles	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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

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Comments on Examination

7

Examiner's Name/Stamp

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SIGNATURE



Signature

11/11/2014

Date