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| **SECTION 1: Personal Information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Surname |  | | | | | | | Given Name | | | | | | |  | | | DOB | | | | | |  | | | | | M  F | |
| Home Address |  | | | | | | | | | | | | | | | | | Post Code | | | | | |  | | | | | | |
| Contact No |  | | | | | | | Email Address | | | | | | |  | | | | | | | | | | | | | | | |
| Emergency Contact Name |  | | | | | | | Relationship | | | | | | |  | | | | | Contact No | | | |  | | | | | | |
| Proposed Occupation |  | | | | | | | | | | | | | | Job Location | | | | | | |  | | | | | | | | |
| **SECTION 2: Work History** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please complete the below table in relation to your work/employment history over the past 2 years | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Occupation/Job Role | | Start Date | | | | | | | | | End Date | | | | | | | | Employer | | | | | | | | | | | |
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| Is the job you are applying for the same type of work you are now doing? | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | |
| Have you previously worked in the same work environment as this job? | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | |
| **Examiner Comments: (Please comment on all YES answers)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SECTION 3: Medication** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please list any medications you are currently taking below (eg. Tablets, pills, injections, puffers or aspirin) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of Medicine | | | Reason (eg. high blood pressure) | | | | | | | | | | | | | | | | | | Taken Regularly? | | | | | | | | | |
|  | | |  | | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | | |
|  | | |  | | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | | |
|  | | |  | | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | | |
|  | | |  | | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | | |
|  | | |  | | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | | |
|  | | |  | | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | | |
| **Examiner Comments: (Please comment on all YES answers)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SECTION 4: General Health** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Have you seen your doctor in the last 6 months concerning your health? | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | |
| Has your weight altered much in the last 2 years? | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | |
| Have you ever had any serious injuries, illness, mental or physical, which required medical treatment for a period of one week or more? | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | |
| Have you ever spent time in hospital? | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | |
| Have you ever had a blood transfusion? | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | |
| Do you have OR have you ever had any of the following? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Diabetes  High blood pressure  Asthma  Emphysema  Varicose Veins  Epilepsy  Fainting or blackout episodes  Cancer or tumour | | | Yes  No  Yes  No  Yes  No  Yes  No  Yes  No  Yes  No  Yes  No  Yes  No | | | | | | | Concussion or head injury  Migraine  Dermatitis/Eczema  Yellow Jaundice (Hepatitis)  Tropical Disease (Ross River Virus, Malaria)  Hormonal condition  Allergies (Please list) | | | | | | | | | | | | | Yes  No  Yes  No  Yes  No  Yes  No  Yes  No  Yes  No  Yes  No | | | | | | |
| **Examiner Comments: (Please comment on all YES answers)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SECTION 5: Occupational Health** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Do you have OR have you ever had a work related disease or injury | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | |
| Have you ever lodged a workers compensation claim?  If yes;  What was the claim for? Eg. Type of injury/illness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  What date was the claim lodged? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  What date was the claim closed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Did you return to normal duties? | | | | | | | | | | | | | | | | | | | | | | | Yes  No  \_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_  Yes  No | | | | | | |
| In the last 6 months, have you lost time from work due to sickness/injury? | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | |
| Have you ever had problems wearing gloves or other personal protective equipment? | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | |
| Have you ever regularly been exposed to: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Chemicals  Noise | Yes  No  Yes  No | | | Radiation  Dust | | | | | Yes  No  Yes  No | | | | | | | | Asbestos  Solvents  Other | | | | | | Yes  No  Yes  No  Yes  No | | | | | | |
| **Examiner Comments: (Please comment on all YES answers)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SECTION 6: Musculoskeletal Health** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Do you have OR have you ever had an injury to any of the below areas? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Neck  Shoulder  Elbow  Wrist or hand | | | | | | | Yes  No  Yes  No  Yes  No  Yes  No | | | | | | Lower back  Hip  Knee  Ankle or foot | | | | | | | | | | | | | | Yes  No  Yes  No  Yes  No  Yes  No | | | |
| **Examiner Comments: (Please comment on all YES answers)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Do you have OR have you ever experienced any of the following symptoms? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cervical (neck) aches & pains  Lower back aches & pains  Sciatica (weakness/tingling in legs) | | | | | | | Yes  No  Yes  No  Yes  No | | | | | | Unexplained pins & needles  Unexplained muscle aches & pains  Unexplained joint aches & pains | | | | | | | | | | | | | | Yes  No  Yes  No  Yes  No | | | |
| **Examiner Comments: (Please comment on all YES answers)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Do you have OR have you ever had any of the following conditions? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Repetitive strain injury (RSI)  Tennis elbow  Carpal Tunnel Syndrome  Hernia  Osteoarthritis | | | | | | Yes  No  Yes  No  Yes  No  Yes  No  Yes  No | | | | | | | Rheumatoid arthritis  Osteoporosis  Fibromyalgia  Broken/fractured bones  Any other condition that affects your muscles, joints or bones | | | | | | | | | | | | | | Yes  No  Yes  No  Yes  No  Yes  No  Yes  No | | | |
| **Examiner Comments: (Please comment on all YES answers)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SECTION 7: Cardiovascular Health** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Do any of your direct family members have OR have ever had heart problems, such as high blood pressure, heart attack etc.? | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | |
| Have you ever undergone chest or heart surgery? | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | |
| Do you have or have you ever had any of the following conditions? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Heart disease  Heart murmurs  Palpitations or irregular heart beat | | | | | | | | Yes  No  Yes  No  Yes  No | | | | | | | | Angina (chest pain)  High blood pressure | | | | | | | | | Yes  No  Yes  No | | | | | |
| **Examiner Comments: (Please comment on all YES answers)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SECTION 8: Respiratory Health** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Do you have or have you ever suffered from any of the following respiratory conditions? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Wheezing asthma or exercise induced asthma  Emphysema  Hay fever | | | | | | | | Yes  No  Yes  No  Yes  No | | | | | | | | Tuberculosis  Chronic obstructive pulmonary disease  Rheumatic fever  Bronchitis | | | | | | | | | Yes  No  Yes  No  Yes  No  Yes  No  Yes  No | | | | | |
| Have you ever coughed up blood? | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | |
| Have you ever experienced an unexplained shortness of breath? | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | |
| **Examiner Comments: (Please comment on all YES answers)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SECTION 9: Ear & Eye Health** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Do you have a loss of hearing? | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | |
| Do you have or have you ever had earaches, ear infections or discharge from your ear? | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | |
| Do you or have you ever been required to use a hearing aid? | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | |
| Do you have or have you ever had an eye injury or condition? | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | |
| Do you wear glasses or contact lenses for either near or distance vision? | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | |
| Are you colour blind? | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | |
| Have you ever had surgery in relation to your eyes or ears? Eg. Laser eye surgery | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | |
| **Examiner Comments: (Please comment on all YES answers)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SECTION 10: Metabolic & Digestive Health** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Do you regularly suffer from indigestion or an upset stomach? | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | |
| Have you ever passed or vomited blood? | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | |
| Have you noticed any recent change in bowel habit? | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | |
| Have you noticed a change in thirst and the number of times you urinate? | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | |
| Have you started waking up at night to urinate? | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | |
| Do you have trouble starting and stopping your urine flow? | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | |
| Have you noticed a change in the strength of your urine flow? | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | |
| **Examiner Comments: (Please comment on all YES answers)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SECTION 11: Mental Health** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Do you have or have you ever had a mental health issue requiring medication or counselling? | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | |
| Have you ever been referred to a psychologist or psychiatrist? | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | |
| Have you ever been prescribed antidepressants, sedatives, or sleeping tablets? | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | |
| Have you ever had a problem with drug or alcohol abuse? | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | |
| Do you have or have you ever had any of the following conditions? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Depression  Panic attacks  Anxiety | | | | | Yes  No  Yes  No  Yes  No | | | | | | | | | Insomnia  Any other mental health condition | | | | | | | | | | | | | | Yes  No  Yes  No | | |
| **Examiner Comments: (Please comment on all YES answers)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SECTION 12: Fatigue & Heat Management** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Do you have or have you ever had a sleep disorder, such as sleep apnoea, or narcolepsy | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | |
| Do you suffer from spells of complete exhaustion? | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | |
| Have you ever had any problems with prolonged shift work? | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | |
| Have you ever worked in a very hot environment? | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | |
| Have you ever had an adverse reaction to working in a very hot environment? | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | |
| Have you ever had a heat-related illness? (eg. heat stroke, heat exhaustion) | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | |
| Have you ever had any treatment that reduces your capacity to sweat? | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | |
| Do you have diabetes, thyroid problems or any other hormonal condition? | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | |
| Do you have or have you ever had kidney stones, bladder stones or renal colic? | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | |
| **Examiner Comments: (Please comment on all YES answers)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SECTION 13: Lifestyle** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| On average, how many standard alcoholic drinks do you drink each day? | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |
| What is the maximum number of standard alcoholic drinks you would drink in one day? | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |
| Do you or have you ever smoked? If yes;   * How many cigarettes do or did you smoke per day?\_\_\_\_\_\_\_\_ * When did you start and stop smoking?\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | |
| How many times per week do you normally exercise? | | | | | | | | | | | | | | | | | | | | | | | | | | 0  1-2  3-5  5 or greater | | | | |
| Do you have any concerns about any aspect of your health? | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | |
| **Examiner Comments: (Please comment on all YES answers)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SECTION 14: Vaccination History** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Have you been vaccinated for the below?  Tetanus  Hep A/Hep B | | | | | | | | | | | | Yes  No  Yes  No | | | | | | | | | | | | | | | | | | |
| **Examiner Comments: (Please comment on all YES answers)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

**PLEASE TURN OVER**

**Release of Medical Information**

I, ……………………………………………………………………………………………………………………………. DOB ……………………………

(Print Name)

* Give full consent for all medical information, past and present - reported, presented to or held by REDiMED to be provided to authorised personnel of my prospective employerfor the purpose of assessing my suitability for the position I have applied for.

❑ Physical Health …………..…………………

(Initials)

❑ Mental Health …………..…………………

(Initials)

* Understand that I will be tested for drugs as part of my Employment Medical Examination and that it is in my interests to reveal any prescription or non-prescription drugs (including vitamins) that I am taking.

Signed: ……………………………………………………………………………………………………………………………………………………………

Witness: …………………………………………………………………………………………………………………………………………………………….

Date: ……………………………………………………………………………………………………………………………………………………………

**Declaration**

I, ……………………………………………………………………………………………………………………………. DOB ……………………………

(Print Name)

* Declare that to the best of my knowledge the answers in this application are correct.
* Understand that if any false or deliberately misleading information is given, or any material facts withheld, I will not be accepted for employment, or if I am employed, my employment may be terminated.
* Authorise the examining doctor to release any information acquired from my medical history, examination and urine drug screen to authorised personnel of my prospective employer.

Signed: ……………………………………………………………………………………………………………………………………………………………

Witness: …………………………………………………………………………………………………………………………………………………………….

Date: ……………………………………………………………………………………………………………………………………………………………