|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Personal Details** (to be filled in by Patient) | | | | | | | | |
| **Surname:** | | | | | **Given Names:** | | | |
| **Date of Birth:** | | **M**  **F** | | | | | **Phone Extension:** | |
| **Home Address:**  **Post Code:** | | | | | | | **Home Phone:**  **Mobile:** | |
| **Next of Kin/Emergency Contact:** | | **Relationship:** | | | | | **Contact No (A/H):**  **Contact No (W/H):** | |
| **Address:** | | | | | | | | |
| **Medical History** (please complete all details fully) | | | | | | | | |
| **Height:** | **Weight:** | | | **Medic Alert:** Yes  No  **Number:** | | | | |
| **Allergies:** Yes  No | | **If yes, please list:** | | | | | | |
| **Please describe symptoms:** | | | | | | |
| **Are you currently vaccinated for Tetanus:** Yes  No  Date of Vaccination::  **Are you currently vaccinated for Hep A/Hep B:** Yes  No  Date of Vaccination: | | | | | | **Current/Regular Medication:** | | |
| **Physical Information:** High BP  Diabetes  Asthma  Emphysema  Heart  Varicose  Veins  Stomach  Communicable diseases  **Other:** | | | | | | | | |
| **Identifying Characteristics:** | | | | | | | | |
| Prosthesis: Eye:  Denture:  Other: | | | | | | | | |
| Glasses:  Contact Lenses:  Other: | | | | | | | | |
| Birthmarks:  Scars:  Tattoos:  Other: | | | | | | | | |
| Other useful medical information: | | | | | | | | |
| **Declaration** | | | | | | | | |
| I declare that the above information is true and correct, and that if any of this information changes, I will inform my company immediately and update these details. | | | | | | | | |
| **Name:** | | | **Sign:** | | | | | **Date:** |

Medical History/Questionnaire

(To be filled out prior to Doctors visit)

***Please answer the following as fully as possible.***

General Heath Questions

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Question** | | **Yes** | | **No** | **Reason/ Example/ Date** |
| 1. | Have you seen your doctor in the last 6 months concerning your health? |  | |  |  |
| 2. | Are you currently taking any medication?  If yes, please state what medication. |  | |  |  |
| 3. | Has your weight altered much in the last two years? How much? |  | |  |  |
| 4 | During a typical work day, how much water do you drink, ie cups, litres? |  | | | |
| 5 | When was your last tetanus injection? |  | |  |  |
| 6 | Do you usually have difficulties falling asleep or staying asleep? |  | |  |  |
| 7 | Have you noticed any abnormal bleeding from anywhere? |  | |  |  |
| 8 | Do you suffer from spells of complete exhaustion? |  | |  |  |
| 9 | Do you or have you ever suffered from fatigue? |  | |  |  |
| 10 | Have you ever had any serious injuries, illnesses, mental or physical, which required medical treatment for a period of one week or more? |  | |  |  |
| 11 | Do you consume alcohol on a regular basis?  If yes: |  | |  |  |
| 1. How many days per week? |  | | |  |
| 1. How many standard drinks on those days? |  | | |
| 12 | Are you a smoker? If yes: |  | |  |  |
| 1. How many cigarettes do you smoke a day (no. of cigarettes)? |  | | |  |
| 1. Tailor made or roll-your-own? |  | | |
| 1. How old were you when you started smoking? |  | | |
| 1. Have you ever smoked? |  |  | |
| 1. When did you start and stop? |  | | |  |
| 1. How many cigarettes did you smoke a day? |  | | |  |
| 13 | Do you exercise regularly? How often and what type of exercise? |  | |  |  |
| 14 | Do you have any concerns about any aspect of your health? |  | |  |  |

Workers’ Compensation / Work related Questions

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Question** | | | | **Yes** | **No** | **Reason/ Example/ Date** | | |
| 1. | Do you or have you had a **work related disease or injury**? | | |  |  |  | | |
| 2. | Have you ever lodged or do you have **a worker’s compensation claim**? | | |  |  |  | | |
|  | 1. **If yes**, what was the injury? | | |  | | | | |
| 3. | In the last 6 months, have you **lost time from work due to sickness**? | | |  |  |  | | |
| 4 | Do you have any health issues that restrict you from completing your work? | | |  |  |  | | |
| 5 | Have you ever had **problems wearing gloves** or **other personal protective equipment**? | | |  |  |  | | |
| 6 | Have you ever been regularly exposed to: | | | | | | | |
|  | **Yes** | **No** |  | | | **Yes** | **No** |
| Chemicals |  |  | Solvents | | |  |  |
| Noise |  |  | Radiation | | |  |  |
| Asbestos |  |  | Dust | | |  |  |
| Other |  |  |  | | | | |

Questions concerning Musculoskeletal Problems

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Question** | | | | **Yes** | **No** | **Reason/ Example/ Date** | | |
| 1. | Have you ever: | | | | | | | |
| 1. Spent time in hospital? | | |  |  |  | | |
| 1. Had a blood transfusion? | | |  |  |  | | |
| 1. Broken or fractured any bones? | | |  |  |  | | |
| 1. Had any other injury **not related to work**, ie from an accident, sport? | | |  |  |  | | |
| 3 | Have you ever had a **cervical (neck) injury**? | | |  |  |  | | |
| 2. | Have you ever suffered a **lumbar (lower back) injury**? | | |  |  |  | | |
| 1. Did this injury result in you having reoccurring lower back pain or sciatica (weakness, tingling in legs) | | |  |  |  | | |
| 3 | Do you have any pain and/or stiffness in: | | | | | | | |
| 1. Cervical (neck) spine | | |  |  |  | | |
| 1. Lumbar (lower back) spine | | |  |  |  | | |
| 4 | Have you ever had **any injury or condition** to your: | | | | | | | |
|  | **Yes** | **No** |  | | | **Yes** | **No** |
| Shoulder |  |  | Hip | | |  |  |
| Elbow |  |  | Knee | | |  |  |
| Wrist |  |  | Ankle | | |  |  |
|  | | | **Yes** | **No** |  | | |
| 5 | Do you or have you ever suffered from **Repetitive Strain Injury (RSI), Occupational Overuse Syndrome, Tennis Elbow, Tendonitis or similar**? | | |  |  |  | | |
| 6 | Do you ever experience **unexplained pins and needles in your hands**? | | |  |  |  | | |
| 7 | Do you suffer from **Arthritis** (ie Rheumatoid arthritis, Osteoarthritis) **or Osteoporosis**? | | |  |  |  | | |
| 8 | Have you ever or do you have **aches and pains in your muscles** that are not related to exercise, ie fibromyalgia? | | |  |  |  | | |
| 9 | Have you ever or do you suffer from **foot trouble or difficulty wearing shoes**? | | |  |  |  | | |

Questions concerning Respiratory and Cardiovascular Health

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Question** | | | | **Yes** | **No** | **Reason/ Example/ Date** | | |
| 1. | Do any of your immediate family members suffer, or have suffered from, heart problems ie high blood pressure, heart attack? | | |  |  |  | | |
| 2 | Have you ever or do you suffer from **Angina (Chest pain)**? | | |  |  |  | | |
| 3 | Have you ever undergone **chest or heart surgery**? | | |  |  |  | | |
| 4 | Have you ever or do you suffer from: | | | | | | | |
|  | **Yes** | **No** |  | | | **Yes** | **No** |
| Heart Disease |  |  | Heart Murmurs | | |  |  |
| Palpitations or Irregular Heart Beat |  |  | High Blood Pressure | | |  |  |
| 5 | Have you ever had or suffer from a **chronic chest condition** such as: | | | | | | | |
| Wheezing Asthma or Exercise Induced Asthma |  |  | Hay Fever | | |  |  |
| Emphysema |  |  | Chronic Obstructive Pulmonary Disease | | |  |  |
| Bronchitis |  |  | Rheumatic Fever | | |  |  |
| Tuberculosis |  |  |  | | | | |
| 6 | Have you ever **coughed up blood**? | | |  |  |  | | |
| 7 | Have you ever had **unexplained shortness of breath**? | | |  |  |  | | |

Questions concerning Head, Ear, Eye and Skin Health

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Question** | | **Yes** | **No** | **Reason/ Example/ Date** |
| 1. | Have you ever had a **head injury or a concussion**? |  |  |  |
| 2 | Have you ever or do you suffer from **frequent headaches or migraines**? |  |  |  |
| 3 | Have you ever or do you suffer from **fits, Epilepsy**? |  |  |  |
| 4 | Have you ever or do you suffer from **blackouts or fainting episodes**? |  |  |  |
| 5 | Do you suffer from **loss of hearing**? |  |  |  |
| 6 | Have you ever or do you suffer **earaches, ear infections or discharge from your ear**? |  |  |  |
| 7 | Have you ever or do you suffer from **eye trouble** ie. Eye injury, lazy eye, loss of vision due to an injury or glaucoma? |  |  |  |
| 8 | Are you **colour blind**? |  |  |  |
| 9 | Do you wear **glasses or contact lenses**?  Please state for near or distance vision. |  |  |  |
| 10 | Have you ever or do you suffer from **Dermatitis/eczema**? |  |  |  |

Questions concerning Stomach, Metabolic Health and other Diseases

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Question** | | **Yes** | **No** | **Reason/ Example/ Date** |
| 1 | Have you ever suffered a **hernia?** |  |  |  |
| 2 | Do you suffer from **indigestion or upset stomach**? |  |  |  |
| 3 | Have you ever or do you suffer from **passing blood or vomiting blood**? |  |  |  |
| 4 | Have you noticed any recent changes in bowel habit? |  |  |  |
| 5 | Have you noticed **a change in thirst** and the number of times you urinate? |  |  |  |
| 6 | Have you started waking up at night to urinate? |  |  |  |
| 7 | Do you have **trouble starting and stopping your urine flow**? |  |  |  |
| 8 | Have you noticed **a change in the strength of your urine flow**? |  |  |  |
| 9 | Have you ever or do you suffer from **Diabetes**? |  |  |  |
| 10 | 1. Are you an insulin dependent Diabetic? |  |  |  |
| 11 | Have you ever or do you suffer from **Yellow Jaundice (hepatitis)**? |  |  |  |
| 12 | Have you ever or do you suffer from **Malaria, Dengue Fever, Rossriver Virus or any other tropical disease**? |  |  |  |

**Statement**

**Section 79 of the Western Australian *Workers' Compensation and Injury Management Act 1981* gives an arbitrator discretion to refuse to award compensation which would otherwise be payable where it is proved that the worker has, at the time of seeking or entering employment in respect of which he claims compensation for an injury, wilfully and falsely represented himself as not having previously suffered from the injury.**

I have read the above statements. The answers are correct, and no information concerning my present or past health has been withheld.

Signed: Date:

Name: