Hospital Street
DOCTORS
day and night care

CONFIDENTIAL PRE-EMPLOYMENT HEALTH ASSESSMENT

Applicant Details

Surname		
Given Names		
Date of Birth		
Date of Medical		
Position applied for		
COMPANY		
Contact Telephone	Home:	Mobile:

Notes to the potential candidate:

You have been selected as a potential candidate for the position for which you have applied. The position is for potential employment with one of the companies for whom we perform Pre-Employment medicals, and in this Pre-Employment Health Assessment form, the reference to Company is taken to be a reference to that Company **only**.

As part of the selection process, it is necessary for potential candidates to undergo a pre-employment medical examination. This is part of the process to confirm that you are suitable to perform the inherent duties of the position for which you have applied, and to help prevent work-related illness and injury occurring subsequent to your employment.

For the purpose of possible future consideration of your employment, or in the case of a dispute, your company will retain your pre-employment medical examination results. If you are employed by the company, the pre-employment medical examination results may also be entered into the Company's computerised medical records system. Use and disclosure of this information should be strictly and confidentially controlled in accordance with the *Candidate Declaration and Informed Consent,* which you will be required to sign before we can proceed with the pre-employment medical examination.

The extent of the pre-employment medical examination depends primarily on the nature of the position for which you have applied, and also takes into consideration statutory requirements and information provided by you in this Health Assessment form. There are no invasive procedures or internal examinations involved in this medical. Use and disclosure of the information provided on this Pre-Employment Health Assessment form will be strictly and confidentially controlled and the form will remain the property of the Company.
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A standard Pre-Employment includes: Blood pressure, vision, height, weight, urinalysis.

A doctor review of medical history questionnaire which includes: Peripheral vision, Oral and ear, respiratory, cardiovascular, abdominal, skin, nervous system, basic musculoskeletal.

Spirometry (Lung Function), Audiometry (Hearing Test), Drug and Alcohol test will be done/referrals made as needed or on request of the prospective employer. These may be at additional private cost to you. Depending on your medical history other tests or referrals may be required and these may be at additional private cost to you. These fees may not be claimed back through Medicare or through private health insurance.

Bookings will be made after the payment only – this is a non refundable payment

You must arrive with the forms filled, which can be found online or collect from the clinic, and bring all relevant documents and medical reports, and other equipment (such as your glasses) so that additional costs will not be incurred for a re-assessment etc. Please bring photo identification, such as driver's licence or passport.

All Pre employment exams will be done by Dr. Pushkara Epa on Tuesday mornings only at present

Please ensure your name is on the top of each page of this Pre-Employment Health Assessment form.

MEDICAL QUESTIONNAIRE Applicant:

Family History

Does your mother, father, brother or sister suffer from any of the following?
If yes, please provide details:

	Yes	***No***	***Details***
Diabetes			
Heart Disease			
Hay Fever			
Tuberculosis			
Asthma			
Epilepsy			
High Blood Pressure			
Eczema			
Stroke			
Other			
General Health			
Do you suffer any disease or disability at present?			
Do you have poor hand or finger circulation (eg Raynaud's Syndrome)?			
Do you have any recurrent health problems that may interfere with your ability to attend work or perform your role? eg difficulties with shiftwork			
Do you have any problem(s) that may affect your safety or the safety of others? (eg daytime sleepiness, sleep apnoea)			
Does your health prevent you from doing anything now?			
Do you suffer a fear of heights, closed spaces or any other phobia?			
Do you usually sleep well?			
Do you wake up during the night – regularly?			

General Health Continued	***Yes***	***No***	***Details***
Have you been told you snore, or stop breathing in your sleep?			
Do you ever feel sleepy during the day?			
Do you fall asleep easily eg while watching TV, or when a passenger in a car?			
Do you drink alcohol?			

If you do drink alcohol, on the average how often?	Less than once a week	
	On 1 or 2 days a week	
	On 3 –4 days a week	
	On 5 – 6 days a week	
	Everyday	
On the days that you do drink alcohol, on average how much do you drink?	1 or 2 standard drinks	
	3 or 4 standard drinks	
	5 to 8 standard drinks	
	9 – 12 standard drinks	
	13 – 20 standard drinks	
	More than 20 standard drinks	

Medical History

Do you have now or have you ever had these conditions? If yes please give a brief explanation

	Yes	***No***	***Details***
Heart problems (eg heart valve problems, Rheumatic Fever, Angina, Heart Attack or Heart Rhythm problems)			
Frequent headaches or migraine			
Epilepsy or fits			
Faints, dizzy spells, turns or blackouts			
Severe nervousness, anxiety, depression or psychological illness			
Indigestion, heartburn or stomach ulcer			
Recurrent diarrhoea or constipation			
Vomiting of or passing blood			
Kidney, bladder or urinary problems			

Medical History Continued

Do you have now or have you ever had these conditions? If yes please give a brief explanation

	Yes	***No***	***Details***
Sugar Diabetes			
Skin disease, rash or skin problems			
Hernia or rupture			
Hepatitis or Liver problems			
Tumour, Cancer or Malignancy			
Ear trouble			
Deafness or difficulty with hearing			
Any sinus, nose or throat problems			
Paralysis or weakness of any cause			
Injury or problem of the back or neck			
Injury or problem of any bones or joints (eg broken bones)			
Any broken bones that have failed to heal completely			
Any chest injuries			
Any operations on your chest (including as a child)			
Eye problems			
Glasses or other corrective lenses			
If yes, describe type and usage			
Do you suffer from any allergies			
If yes, describe type			

Medical History - General

Do you have now or have you ever had these conditions? If yes please give a brief explanation

	Yes	***No***	***Details***
Tuberculosis (TB)			
High Blood Pressure			
Asthma			
Wheezy or allergic bronchitis			
Emphysema			
Chronic Obstructive Airways Disease			
Pneumonia			
Hay Fever			
Pleurisy			
Any other illness or injury, including surgical operations			
Have you every used any inhalers?			
If yes – give types and reasons for use and when last used			
Have you taken any cold/flu medicines or tablets in the past month?			
If yes – give type and when last used			
Do you currently have a cold , the “flu” or any chest complaint?			
Do you smoke			
If yes – how many per day_____ For how many years _____			
Have you ever smoked previously?			
If yes – what year did you quit_____How many years had you smoked _____			

Medical History - Occupational Do you have now or have you ever had these conditions? If yes please give a brief explanation			
	Yes	***No***	***Details***
Have you suffered any illness or injury caused by your occupation?			
Have you ever had difficulties wearing PPE?			
Have you ever lived or worked outside Australia?			
Have you ever worked shifts?			
Do you sleep well when working nights?			
Have you ever had a heat related illness or rash?			
Have you ever worked with asbestos?			
Have you ever worked with hazardous materials?			
Have you ever been exposed t o chemicals, dust or fume at work?			
Have you ever worked in a noisy environment ? (where you had to raise your voice to be heard)			

Medications Are you currently taking any of the following?			
	Yes	***No***	***If yes - please provide name of medication and the reason you are taking it and when you took the last dose***
Prescribed medication (a Doctor must give you a script for this)			
Over the counter medications (vitamins, pain killers, anti-inflammatories, naturopathic remedies)			
Any inhaled medications			

Vaccination History Have you ever been vaccinated against any of the following diseases – if yes, give approximate date/year in space provided				
Influenza		Typhoid		
Tetanus		Polio		
Hepatitis A		Meningococcal		
Hepatitis B		Pneumonia		
MMR – Measles, Mumps, Rubella		Cholera		
TB -Tuberculosis		Yellow Fever		
Diphtheria		Japanese Encephalitis		
Q Fever				

To be signed by the candidate in the presence of
examining Nurse or Medical Officer

Declaration
I have not knowingly withheld any information relevant to the pre-employment medical examination. I declare that the information provided in this Pre-Employment Health Assessment form is true and correct.

Consent to Disclosure
I understand that the Company will require me to satisfactorily undergo a pre-employment medical examination as a condition of appointment for the position to which I have applied. I authorise the examining nurse, paramedic or medical practitioner to release any relevant information to the Company designated Occupational Health Advisor.

I understand that information obtained in this Pre-Employment Health Assessment form and pre-employment medical examination will only be disclosed to the Company designated Occupational Health Advisor. If persons other than the designated Occupational Health Advisor require access, this will only occur with my prior written consent , subject to the following exceptions:

- Leaders in my direct line of management will be advised of my fitness to work, any work restrictions required, if there has been any excessive exposure to a hazardous agent at work or if a work related injury or illness has occurred. However, any clinical medical details will only be disclosed with my prior written consent; and

- Information will be disclosed in response to a court order, if required by legislation or in specific legal circumstances permitted under applicable Privacy Legislation.

Right of Access
I understand that I have the right to access, and where necessary correct, personal health information held about me by the Company. To obtain access I understand that I will need to contact the Company designated Occupational Health Advisor.

Consent to Use
I understand that for the purpose of possible future consideration of employment with the Company, or in the case of a dispute, the Company will retain the information in this Pre-Employment Health Assessment form and my pre-employment medical examination results for a period of 12 months. If I am employed by the Company, the information in this Pre-Employment Health Assessment form and pre-employment medical examination results may be entered into the Company's computerised medical records system. Use and disclosure of this information will be controlled in accordance with this *Candidate Declaration and Informed Consent.*.

I have read the information in this Pre-Employment Health Assessment form and had an opportunity to discuss it with a nurse/doctor. I have had any questions answered to my satisfaction. I grant my informed consent to complete the **'Family Practice'** pre-employment medical examination

Applicants Signature: _____

Applicants Name Printed:_____Date: _____

The candidate has been given the Pre-Employment Health Assessment form and has stated to me that he/she has thoroughly read and understands the document. I have explained to him/her all of the information contained in it. I am of the opinion that he/she is giving informed consent and wishes to proceed with the Comalco pre-employment medical examination.

OH Nurse or Medical Officer Signature: _____

Name Printed: _____

Date: _____