



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.

You will be required to undergo a number of tests including Spirometry (Lung Function), Audiometry (Hearing Test), Drug and Alcohol test, Vision Screening, Urinalysis, finger prick Cholesterol and Physical Functional Capacity Assessment. You will be examined and asked to remove some of your clothing i.e. shirt or blouse.

You will be required to provide photo identification, such as driver's licence or passport. Please bring prescription glasses if you wear them and copies of any relevant medical reports you may have.

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
1	Diabetes			
2	Heart Disease			
3	Hay Fever			
4	Tuberculosis			
5	Asthma			
6	Epilepsy			
7	High Blood Pressure			
8	Eczema			
9	Stroke			
10	Other			

General Health

11	Do you suffer any disease or disability at present?			
12	Do you have poor hand or finger circulation (eg Raynaud's Syndrome)?			
13	Do you have any recurrent health problems that may interfere with your ability to attend work or perform your role? eg difficulties with shiftwork			
14	Do you have any problem(s) that may affect your safety or the safety of others? (eg daytime sleepiness, sleep apnoea)			
15	Does your health prevent you from doing anything now?			
16	Do you suffer a fear of heights, closed spaces or any other phobia?			
17	Do you usually sleep well?			
18	Do you wake up during the night – regularly?			

General Health Continued		Yes	No	Details
19	Have you been told you snore, or stop breathing in your sleep?			
20	Do you ever feel sleepy during the day?			
21	Do you fall asleep easily eg while watching TV, or when a passenger in a car?			
22	Do you drink alcohol?			
23	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	
24	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
25	Heart problems (eg heart valve problems, Rheumatic Fever, Angina, Heart Attack or Heart Rhythm problems)			
26	Frequent headaches or migraine			
27	Epilepsy or fits			
28	Faints, dizzy spells, turns or blackouts			
29	Severe nervousness, anxiety, depression or psychological illness			
30	Indigestion, heartburn or stomach ulcer			
31	Recurrent diarrhoea or constipation			
32	Vomiting of or passing blood			
33	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
34	Sugar Diabetes			
35	Skin disease, rash or skin problems			
36	Hernia or rupture			
37	Hepatitis or Liver problems			
38	Tumour, Cancer or Malignancy			
39	Ear trouble			
40	Deafness or difficulty with hearing			
41	Any sinus, nose or throat problems			
42	Paralysis or weakness of any cause			
43	Injury or problem of the back or neck			
44	Injury or problem of any bones or joints (eg broken bones)			
45	Any broken bones that have failed to heal completely			
46	Any chest injuries			
47	Any operations on your chest (including as a child)			
48	Eye problems			
49	Glasses or other corrective lenses			
If yes, describe type and usage				
50	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
51	Tuberculosis (TB)			
52	High Blood Pressure			
53	Asthma			
54	Wheezy or allergic bronchitis			
55	Emphysema			
56	Chronic Obstructive Airways Disease			
57	Pneumonia			
58	Hay Fever			
59	Pleurisy			
60	Any other illness or injury, including surgical operations			
61	Have you every used any inhalers?			
If yes – give types and reasons for use and when last used				
60	Have you taken any cold/flu medicines or tablets in the past month?			
If yes – give type and when last used				
61	Do you currently have a cold , the “flu” or any chest complaint?			
62	Do you smoke			
If yes – how many per day _____ For how many years _____				
63	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
64	Have you suffered any illness or injury caused by your occupation?			
65	Have you ever had difficulties wearing PPE?			
66	Have you ever lived or worked outside Australia?			
67	Have you ever worked shifts?			
68	Do you sleep well when working nights?			
69	Have you ever had a heat related illness or rash?			
70	Have you ever worked with asbestos?			
71	Have you ever worked with hazardous materials?			
72	Have you ever been exposed to chemicals, dust or fume at work?			
73	Have you ever worked in a noisy environment ? (where you had to raise your voice to be heard)			

Employment History			
List your last three positions and the start and finish date for each			
Company	Position Held	Start	Finish
1			
2			
3			

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
78	Prescribed medication (a Doctor must give you a script for this)			
79	Over the counter medications (vitamins, pain killers, anti-inflammatories, naturopathic remedies)			
80	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

64	Influenza		71	Typhoid	
65	Tetanus		72	Polio	
66	Hepatitis A		73	Meningococcal	
67	Hepatitis B		74	Pneumonia	
68	MMR – Measles, Mumps, Rubella		75	Cholera	
69	TB -Tuberculosis		76	Yellow Fever	
70	Diphtheria		77	Japanese Encephalitis	

**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: _____

MEDICAL ASSESSMENT**Applicant:** _____*To be completed by Occupational Health Nurse/Medical Officer***Date of Assessment:** _____

Height		Weight	
BMI		Blood Pressure	
Urinalysis	SG Glucose	Protein Ketones	Blood Other
Vision			Together
Near	Without correction	R (N) L (N)	(N)
	With correction	R (N) L (N)	
Distance	Without correction	R 6/ L 6/	6/
	With correction	R 6/ L 6/	
Colour Vision	Pass <input type="checkbox"/> Fail <input type="checkbox"/>	Ishihara Plates – Numbers of plates misread:	

	<i>Results</i>	<i>Comments</i>
Medical Questionnaire		
Biometry		
Audiometry		
Spirometry		
Drug & Alcohol Test		
Functional Capacity Assessment		
Cardiac Risk Assessment		
Fatigue/Shiftwork Assessment		
Medical Officer Review Required No <input type="checkbox"/> Yes <input type="checkbox"/>		

RECOMMENDED STANDARDS FOR PRE-EMPLOYMENT MEDICALS

If the potential candidate does not meet the following standards the advice of the Company Occupational Health Advisor will be sought in relation to the role specific requirements and assessment of risk.

Weight	
Blood Pressure	
Cardiac	
Renal	
Vision	
Diabetes	
Spirometry	
Audiometry	
CNS	
Functional Assessment	

Fitness for Work /Medical Assessment completed by:

Signature: _____

Date: _____ Printed: _____

A		Fit for all duties
B		Fit for proposed role with the following restrictions:
C		Not suitable for any roles at the Company

Comments: _____

Company Occupational Health Advisor _____

Date: _____