BLH GROUP OF COMPANIES

PRE EMPLOYMENT MEDICAL ASSESSMENT FORM

SECTION A – APPLICANT REPORT **APPLICANT TO COMPLETE PAGES 1 – 2**

1. Personal Details

Surname:	First Name:	Middle Name:
Date of Birth:	☎ Phone Number:	☎ Mobile:
Address		Suburb:
State:	Postcode:	
Proposed Position:		
Proposed Employer:		
Date of Examination: Day	Month	Year

2. **Occupational History** *(Please give details of current and previous work history)*

Company	No. of years	Job Title	Any significant poison or chemical exposure?	
1.			Yes ☐	No ☐
2.			Yes ☐	No ☐
3.			Yes ☐	No ☐
4.			Yes ☐	No ☐
5.			Yes ☐	No ☐

3. Personal Health History

	Yes	No	**If yes, give details**
Are you currently being treated by any doctor for any illness?	☐	☐	_____
Are you currently taking any medications including inhalers?	☐	☐	_____
Are you allergic to anything?	☐	☐	_____
Have you had any broken bones or fractures?	☐	☐	_____
Do you suffer from back, neck or spinal problems Including whiplash?	☐	☐	_____ _____
Have you visited a chiropractor or physiotherapist in the last year?	☐	☐	_____
Have you ever had an X-ray or scan of your neck or back?	☐	☐	_____ _____
Have you ever had trouble wearing any personal protective equipment?	☐	☐	_____
Have you, in the last two years, lost time from work because of an illness or injury?	☐	☐	_____ _____
Have you been exposed to any toxic substances or environmental hazards?	☐	☐	_____
Do you suffer or have you ever suffered from occupational overuse syndrome (E.g. tennis elbow or Tenosynovitis)?	☐	☐	_____ _____

4. Do you now, or have you ever had the following? (please tick box)

Yes	No		Yes	No		Yes	No	
☐	☐	Hernia	☐	☐	Hay Fever	☐	☐	Palpitations / Irregular heart beats
☐	☐	Rheumatic Fever	☐	☐	Wheezing / Asthma	☐	☐	Shortness of breath
☐	☐	Dermatitis / eczema / psoriasis	☐	☐	Heart trouble, angina, chest pain	☐	☐	High blood pressure
☐	☐	Hearing defect	☐	☐	Other mental disorder	☐	☐	Arthritis
☐	☐	Depression	☐	☐	Blackouts / fainting	☐	☐	Ankle or knee trouble
☐	☐	Anxiety / Stress	☐	☐	Kidney disease / bladder problems	☐	☐	Cancer or tumour of any kind
☐	☐	Frequent or migraine headaches	☐	☐	Head injury, or concussion	☐	☐	An injury requiring an operation
☐	☐	Eye trouble	☐	☐	Epilepsy / fits	☐	☐	Other joint injuries or conditions
☐	☐	Back pain, back injury	☐	☐	Diabetes	☐	☐	Deep Vein Thrombosis

Comment: _____

_____

_____

IS there any history of serious illness or disease in your immediate family? Yes ☐ No ☐
If Yes, please provide details when you see the doctor.

Do you:

Yes	No		Yes	No	
☐	☐	Engage in regular exercise	☐	☐	Smoke or have ever smoked. If Yes, number of cigarettes (per day): _____
☐	☐	Drink alcohol? If Yes, average number of standard drink per week _____			
☐	☐	Have an illness or injury not stated above. If Yes, provide details _____			

Do you have difficulty with any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Crouching / Bending / Kneeling	☐	☐	Walking on uneven ground	☐	☐	Shift work / sleep
☐	☐	Lifting heavy weights	☐	☐	Sitting for extended periods of time	☐	☐	Working in hot / cold extremes
☐	☐	Repetitive movement of hands / arms	☐	☐	Confined spaces	☐	☐	Standing for extended periods of time
☐	☐	Walking up stairs / ladders	☐	☐	Working at heights	☐	☐	Working above shoulder height

When was your last tetanus injection?_____

Do you have or have ever had; any other condition not mentioned that may impact your ability to safely perform the duties required of you?

_____

_____

I hereby certify that the foregoing particulars are to the best of my knowledge and correct.

I authorise …… (Medical Examiner) to release my information acquired from this examination to my employer / prospective employer.

_____
Signature

_____
Date

_____
Print Name

SECTION B – MEDICAL EXAMINATION **TO BE COMPLETED BY MEDICAL PRACTICIONER ONLY**

1. Measurements

Height: Weight: Body Mass Index (If required):

Visual Acuity			**Distance Vision**						**Close Vision**					
Uncorrected			Corrected						Uncorrected			Corrected		
Right	6		Right	6					Right	N		Right	N	
Left	6		Left	6					Left	N		Left	N	
Both	6		Both	6					Both	N		Both	N	

Colour vision

Plate	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
Number																								

Normal _____ Abnormal _____

Blood Pressure

BP		Additional reading if required	

Pulse Rate

Resting _____

Pulse Rhythm

Regular **Yes** ☐ **No** ☐

Electrocardiogram (if required)

Normal _____ Abnormal _____ Report Attached _____

2. General

		Yes	**No**	Provide details if required
a)	Does the appearance correspond with age stated?	☐	☐	
b)	Is there anything unfavourable in appearance?	☐	☐	
c)	Any dermatitis, skin rash, infection?	☐	☐	

3. Respiratory System

		Yes	**No**	Provide details if required
a)	Is breathing normal and regular in character?	☐	☐	
b)	Is there any abnormality on examination?	☐	☐	
c)	Is there any sign of past or present respiratory disease?	☐	☐	

4. Circulatory System

		Yes	**No**	Provide details if required
a)	Are there any abnormalities cardiac auscultation?	☐	☐	
b)	Is there any abnormalities in the heart rate or rhythm?	☐	☐	

5. Digestive system

		Yes	**No**	Provide details if required
a)	Is there evidence of abnormality of the tongue mouth or throat?	☐	☐	
b)	Is there evidence of abnormality for abdominal organs, including liver and spleen?	☐	☐	
c)	Is a hernia present?	☐	☐	

SECTION B – MEDICAL EXAMINATION **TO BE COMPLETED BY MEDICAL PRACTICIONER ONLY**

6. Spine and Nervous System	**Yes**	**No**	Provide details if required
a) Is there evidence of disease of the brain or spinal cord?	☐	☐	
b) Is there any defect in sight, hearing or speech?	☐	☐	
c) Is there evidence of abnormality for:			

	Yes	**No**
• Shoulders	☐	☐
• Elbows	☐	☐
• Hands	☐	☐
• Hips	☐	☐
• Knees	☐	☐
• Ankles	☐	☐
• Feet	☐	☐
• Cervical Spine	☐	☐
• Thoracic Spine	☐	☐
• Lumbar Spine	☐	☐

d) Reflexes

Is there evidence of abnormality for?	**Yes**	**No**	*Provide details if required*
• Biceps	☐	☐	
• Triceps	☐	☐	
• Supinator	☐	☐	
• Knee	☐	☐	
• Ankle	☐	☐	

e) SLR: L: _____ degrees R: _____ degrees

f) Posture: Good _____ Average _____ Poor _____

g) **Balance:** _____

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SECTION C – MEDICAL EXAMINATION

TO BE COMPLETED BY MEDICAL PRACTICIONER AND RETURNED TO REQUESTING PARTY

1. PERSONAL DETAILS

Surname:	First Name:	Middle Name:
Date of Birth:	☎ Phone Number:	☎ Mobile:
Proposed Position:		
Proposed Employer:	Date of Examination: _____ / _____ / _____	

2. TYPE OF EXAMINATION PERFORMED

Employment Medical ☐ Drug and Alcohol Screen ☐

Baseline Hearing Test ☐ Spirometry ☐

3. DRUG AND ALCOHOL RESULTS

See Attached ☐ No substance detected ☐ Substances detected ☐

Comments: _____

_____

4. DECLARATION OF ALLERGIES, PRESCRIBED MEDICATION OR OTHER CONDITIONS

People with certain medical conditions are at risk of aggravating their conditions when working at the ..... (Project Details).

To help us identify those people, you are asked to confirm the following information:

(Please complete table below)	Yes	No
i) Is the person currently taking any prescribed medication on a regular basis that a Site Medical Centre should Be made aware of?		
ii) Does the person suffer from any Allergy		
iii) Does the person suffer from any other condition that affect their well being or impact on the individuals Ability to meet required Industry standards or safety regulations for the position they have applied for?		

CONDITION	POTENTIAL IMPACT	RECOMMENDATIONS

5. I AM OF THE OPINION THAT THE ABOVE MENTIONED PERSON IS:

☐ Fit for proposed employment position

☐ Fit for proposed employment position, with following restrictions:

_____

_____

☐ Potentially unsuitable for proposed employment (as per relevant Health & Safety / Industry standards). Further discussion required.

_____	_____	_____
Name of *Practitioner*	Signature	Date

PLEASE NOTE this examination is not for the purpose of determining the success or otherwise of the person's application for employment.

On completion, please return to BLH on Fax No. 03 6383 4906. For enquiries please call 03 6383 4333.