Wheelers Hill CLINIC

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PRE-EMPLOYMENT ASSESSMENT

MEDICAL HISTORY

SURNAME: _____ FIRST NAMES: _____

ADDRESS: _____ SEX: M/F _____

_____ HOME PHONE No. _____

PROPOSED EMPLOYER: _____ DATE OF BIRTH: _____

JOB DESCRIPTION: _____

_____

1. Do you have any ongoing medical conditions?..... **YES** ☐ **NO** ☐

Have you received any medical treatment in the past 12 months?..... **YES** ☐ **NO** ☐

Are you taking any medications?..... **YES** ☐ **NO** ☐

Details: _____

_____

2. Have you ever had any operations, fractures or injuries or been in hospital (apart from child birth) **YES** ☐ **NO** ☐

Year ___ Details: _____

Year ___ Details: _____

3. Have you ever suffered any work-related injuries/conditions?..... **YES** ☐ **NO** ☐

If yes, list details, including any time off work.

Year ___ Injury: _____ TIME OFF: _____

Year ___ Injury: _____ TIME OFF: _____

4. Have you **ever** had:

	YES	NO		YES	NO
Back injury, slipped disc, sciatica, lumbago?.....	☐	☐	Epilepsy, fits, faints, blackouts, dizzy spells,		
Whiplash injury, neck trouble?.....	☐	☐	significant headaches?.....	☐	☐
Rheumatism, arthritis, tenosynovitis?.....	☐	☐	High blood pressure, chest pain, heart trouble?	☐	☐
Joint trouble,e.g. knee, shoulder, wrist, other joints?	☐	☐	Asthma, chronic bronchitis, T.B., emphysema?.	☐	☐
Tennis elbow, golfers elbow, repetitive strain injury			Nervous disorder, mental illness, breakdown?..	☐	☐
(RSI).....	☐	☐	Diabetes, kidney or thyroid trouble?.....	☐	☐
Allergy to chemicals or other workplace substances?	☐	☐	Varicose veins, clots or blocked arteries?.....	☐	☐
Stomach ulcer, hepatitis, pancreatitis, jaundice?.....	☐	☐	Skin rashes, dermatitis, eczema, psoriasis?.....	☐	☐
Work-related stress?.....	☐	☐	Hernia, bowel or bladder disease?.....	☐	☐

Any other pre existing injuries &/or diseases (please list) : _____

	YES	NO
5. Do you have any loss of hearing, or ringing in the ears.....	☐	☐
Have you ever had significant exposure to noise?.....	☐	☐
Have you ever had significant exposure to dust, chemicals or radiation?.....	☐	☐
Have you ever had trouble wearing gloves or other protective equipment?.....	☐	☐
Do you have eye trouble (other than short or long sightedness)?.....	☐	☐
Do you wear glasses or contact lenses?.....	☐	☐
Do you have any infectious diseases?.....	☐	☐

6. Last tetanus injection?..... 19..... >10 years ago ☐ , don't know ☐ , never had ☐

Hepatitis B injection?..... 19..... >10 years ago ☐ , don't know ☐ , never had ☐

7. What is your daily intake of Alcohol? _____

Cigarettes? _____

8. Have you ever been refused a job, life insurance, superannuation or military service for health reasons?…….…….. **YES** ☐ **NO** ☐

DECLARATION: To the best of my knowledge, the above answers are correct. Failure to disclose, or providing false and misleading information may effect your entitlement to compensation as set out in the Workplace Injury Rehabilitation and Compensation Act 2013(Vic) subsection 41(2).
I hereby authorise that any information revealed by this medical examination be provided to my proposed employer.

SIGNED: _____ DATE: _____

The Examining Doctor wishes to make it known that the purposes of this examination and the consequent opinions expressed are in the interests of prevention of industrial injury by the proper placement of employees in those positions best suited to their physical capabilities. This examination is not for the purpose of determining the success or otherwise of this person's application for employment.

CLINICAL EXAMINATION

HEIGHT: _____ cms. WEIGHT: _____ kgs.

VISION (unassisted): Right 6/ Left 6/
(assisted): Right 6/ Left 6/

NEAR VISION: Right N ___ Left N ___

COLOUR VISION (Ishihara): Normal ☐ Abnormal ☐

URINE: Protein yes / no Glucose yes / no Blood yes / no

BLOOD PRESSURE: _____ PULSE: _____ beats/min., regular/irregular

URINE DRUG SCREEN	Performed ☐	Not Performed ☐	
Photo Identification Sighted by:_____	**Type of ID** _____		
DRUG SCREEN RESULT	Negative ☐	Positive ☐	Sent to Lab for confirmation if positive ☐
BLOOD ALCOHOL BREATH TEST	Performed ☐	Not Performed ☐	
	Negative ☐	Positive ☐	Alcohol level if positive _____

	NORMAL	ABNORMAL			YES	NO
HEART……	☐	☐	_____	HERNIAE……..	☐	☐
LUNGS……	☐	☐	_____	VARICOSE VEINS……..	☐	☐
ABDOMEN…….	☐	☐	_____	DEFORMITIES……	☐	☐
C.N.S……..	☐	☐	_____	SCARS…….	☐	☐
SKIN……	☐	☐	_____			
BACK……..	☐	☐	_____			
NECK……..	☐	☐	_____			
HIPS……	☐	☐	_____			
KNEES……	☐	☐	_____			
JOINTS……..	☐	☐	_____			

AUDIOMETRY: Normal ☐ Abnormal ☐ Not performed ☐

SPIROMETRY: Normal ☐ Abnormal ☐ Not performed ☐

COMMENTS: _____

_____

_____

_____

FUNCTIONAL CAPACITY ASSESSMENT	**YES**	**NO**
20KG FROM FLOOR TO 1M BENCH……..…	☐	☐
20KG TRANSFER 5M TO 1M BENCH……..	☐	☐
10KG ABOVE HEAD FOR 20 SECONDS……	☐	☐
20 SQUATS……...	☐	☐
GRIP STRENGTH ……	Right _____	Left _____

MEDICAL EXAMINER: NAME: _____ DATE: _____

SIGNATURE: _____