IMMEX
Injury Management and Medical Examinations
Leaders in Occupational Healthcare

561 Botany Road Waterloo NSW 2017
Tel: 02 9319 5999
Fax: 02 9319 5990
36 Cowper St Parramatta NSW 2150
Tel: 02 8960 9133
Fax: 02 9633 9459
Email: info@immex.com.au

OCCUPATIONAL MEDICAL EXAMINATION - CONFIDENTIAL

Have you ever been to this practice before? **YES** ☐ **NO** ☐

PERSONAL DETAILS Title: Mr / Mrs / Ms / Miss / Other _____

First Name:		Surname:		
Address:				
Suburb:			Postcode:	
Date of Birth:				
Telephone Numbers	Home:		Mobile:	
Company Referring:				
Proposed Job:				

OCCUPATIONAL HISTORY:
Please write details of all jobs you have had in your whole life, in this country or any other.

COMPANY NAME	OCCUPATION or DUTIES	APPROX FROM	DATES TO	EXPOSURE TO DUST/CHEMICALS	NOISY	HEAVY LIFTING IN JOB		
				Yes/No	Yes/No	Rarely	Sometimes	Often

Have you ever had a work-related injury/illness, or been in a motor vehicle accident even if you did not need time off work, and even if it was in another country? **YES** ☐ **NO** ☐
If yes, give details – year, employer, injury, time off work

_____

_____

Have you ever filled a compensation form in Australia, or any other country, even if you did not need time off work? **YES** ☐ **NO** ☐
If yes, give details – year, type of injury/compensation

_____

_____

Health questionnaire concerning: **Applicants name** _____

HEALTH ASSESSMENT CONTINUED:

Have you ever had a problem due to chemicals, dust, working in extreme temperatures, a reaction to foods including peanuts, seafood or any other substance? **YES** ☐ **NO** ☐
If yes, give details:

_____

_____

Have you had a food-borne illness or food poisoning in the past 4 weeks? **YES** ☐ **NO** ☐
If yes, give details:

_____

_____

The examining doctor declares that the purpose of this examination and the opinions expressed are in the interests of the prevention of occupational injury by the proper placement of employees in those positions best suited to their physical capabilities. The examination is not for the purpose of determining the success or otherwise of this person's application for employment.

1. DO YOU SMOKE? Never smoked ☐ Ex-smoker ☐ Current smoker ☐

2. DO YOU REGULARLY EXERCISE? *(Regular sport, gym, or brisk walking for ½ hour or more)*

☐ 3 or more times per week	☐ Weekly on average	☐ Occasionally	☐ Rarely or never

Please describe:

_____

3. DO YOU DRINK ALCOHOL? Yes ☐ No ☐ *(If no go to question 4)*

How often do you drink?	On those days when you have a drink how many drinks would you have?
☐ Every day	☐ 1 to 2 drinks
☐ 3 or 4 days each week	☐ 3 to 4 drinks
☐ Twice a week	☐ 5 to 8 drinks
☐ Once a week	☐ 9 to 12 drinks
☐ Once or twice a month, or less	☐ More than 12 drinks

4. DO YOU USE RECREATIONAL DRUGS? **YES** ☐ **NO** ☐

If YES give details:

_____

5. REGULAR MEDICINES: Are you taking any regular medications, or during the last five years, have you needed to take any medication (other than the oral contraceptive pill) **YES** ☐ **NO** ☐ for more than two weeks?

Name of medication	Length of treatment	Other comments

Health questionnaire concerning: **Applicants name** _____

HEALTH ASSESSMENT CONTINUED:

6. MEDICAL HISTORY

Are you receiving or contemplating any operation, medical or surgical treatment, or test?	☐ **YES**	☐ **NO**
If YES give details.		
Have you ever had an operation or been in hospital? If YES give details.	☐ **YES**	☐ **NO**

Medical history continued: Please tick 'YES' or 'NO' box for each of the following questions

	*Have you **ever** had **or** do you have **now**:*	**YES**	**NO**
1	Any neck or shoulder injury or problem		
2	Any arm or hand problem, or 'RSI'		
3	Any back injury or problem		
4	Any leg injury or problem		
5	Any broken bones		
6	Any problems running 100 metres		
7	Joint injury, pain, swelling or problem		
8	Abnormal shortness of breath		
9	Excess sleepiness, snoring or sleep apnoea		
10	High blood pressure		
11	Heart disease or circulation problem		
12	Bronchitis, pleurisy or persistent cough		
13	Coughing up blood		
14	Tuberculosis (TB) or 'consumption'		
15	Asthma		
16	Hay fever		
17	Other nose or throat trouble		
18	Discharging ears		
19	Deafness		
20	Do you wear glasses for reading		
21	Do you wear glasses for distant vision		
22	Do you wear contact lenses		
23	Eye problem of any sort		
24	Any paralysis (including polio)		
25	Fainting attacks or blackouts		
26	Fits, or epilepsy of any kind		
27	Severe headaches or migraine		
28	Head injury or concussion		
29	Nervous breakdown or mental illness or anxiety or depression		

	*Have you **ever** had **or** do you have **now**:*	**YES**	**NO**
30	Fear of heights		
31	Fear of confined spaces		
32	Addiction or counselling for drugs		
33	Addiction or counselling for alcohol		
34	(Women) Are you pregnant?		
35	Kidney or bladder disease		
36	Recurrent indigestion or reflux		
37	Stomach or duodenal ulcer		
38	Vomiting blood or passing blood		
39	Recurrent diarrhoea or dysentery		
40	Haemorrhoids (piles)		
41	Diabetes		
42	Jaundice, hepatitis, liver or pancreas illness		
43	Immune disorder or HIV		
44	Malaria or any tropical disease		
45	Thyroid disorder, or goitre		
46	Hernia, or rupture		
47	Lump, tumour or any form of cancer		
48	Foot trouble, bunions, hammer toe		
49	Varicose veins or leg ulcers		
50	Dermatitis, eczema or rash		
51	Recent unexplained weight loss		
52	Reaction to drug or injection		
53	Allergies		
54	Strain or ganglion or tennis elbow		
55	Any other illness or injury		
56	Tablets or medicines in last 12 months		
57	Blood test or xray in last 12 months		
58	Do you have any problem wearing safety boots or safety equipment?		

Health questionnaire concerning: **Applicants name** _____

IF **YES** TO ANY OF THE ABOVE QUESTIONS PLEASE WRITE THE QUESTION NUMBER BELOW AND GIVE DATE AND FULL DETAILS OF THE INJURY OR ILLNESS, INCLUDING PRESENT STATUS.
- If space below is not sufficient to complete your answers turn page over and write on the back of this page.

_____

_____

_____

Are you aware of anything that might affect your ability to perform ANY of the duties of the position for which you are applying?	**YES ☐ NO☐**
If YES give details:	

For all 10 questions below, please tick the answer that most applies to you:

In the past 4 weeks	1 none of the time	2 a little of the time	3 some of the time	4 most of the time	5 all the time
1. About how often did you feel tired out for no good reason?					
2. About how often did you feel nervous?					
3. About how often did you feel so nervous that nothing could calm you down?					
4. About how often did you feel hopeless?					
5. About how often did you feel restless or fidgety?					
6. About how often did you feel so restless you could not sit still?					
7. About how often did you feel depressed?					
8. About how often did you feel that everything is an effort?					
9. About how often did you feel so sad that nothing could cheer you up?					
10. About how often did you feel worthless?					

STATEMENT

The answers I have given in this health questionnaire are true and complete to the best of my knowledge.

I am prepared to undergo a medical examination. I authorise the examining doctor/IMMEX to discuss and/or forward all relevant information about me to the referrer. I understand that this examination does not replace any regular medical check-up with my own doctor.

Urine Drug screen required by referrer ☐ YES ☐ NO

I Do/Do not consent to under go any drug screen test as required by the referrer.
(*Do not sign until witnessed by the doctor's staff*)

Signature of Applicant: _____ Dated:

Signature of Witness: _____