PRE-PLACEMENT MEDICAL ASSESSMENT CANDIDATE QUESTIONNAIRE

OCCUPATIONAL MEDICAL EXAMINATION – CONFIDENTIAL **QUESTIONNAIRE**

PERSONAL DETAILS **TITLE:** Mr / Mrs / Ms / Miss / Other: ___________

First Name		Surname:	
Date of Birth:		Mob:	
Address:			
Company Referring:			
Proposed Job:			

OCCUPATIONAL HISTORY

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

Employer			
Year			
Nature of 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?
If yes, give details – year, type of injury/compensation ☐ **YES** ☐ **NO**

Employer			
Year			
Nature of Injury			

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:

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36-46 Cowper Street
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LinkedIn
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LEADERS IN OCCUPATIONAL HEALTHCARE

Health questionnaire concerning: **Applicants name** ______________________________________

1. Do you smoke? ☐ Never smoked Ex-smoker ☐ Current smoker

2. Do you regularly exercise *(Regular sport, gym, brisk walking for ½ hour or more)*

☐ 3x or more per week ☐ Weekly on Average ☐ Occasionally ☐ Rarely/Never

3. Do you drink Alcohol? ☐ Yes ☐ No *(If no, go to Q4)*

How often do you drink?	**On those days, how many drinks would you have?**
☐ Everyday	☐ 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) for more than two weeks? ☐ Yes ☐ No

Name of medication	Length of treatment	Other comments

6. Medical History

Are you receiving or contemplating any operation, medical or surgical treatment or tests? ☐ Yes ☐ No
If YES, give details
Have you ever had an operation or been in the hospital? ☐ Yes ☐ No
If YES, give details

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Health questionnaire concerning: **Applicants name** ___________________________________

Medical history continued: Please tick YES or NO

	*Have you **ever** had **or** do you have **now**:*	YES	NO			*Have you **ever** had **or** do you have **now**:*	YES	NO
1	Any neck or shoulder injury or problem				30	Fear of heights		
2	Any arm or hand problem, or 'RSI'				31	Fear of confined spaces		
3	Any back injury or problem				32	Addiction or counselling for drugs		
4	Any leg injury or problem				33	Addiction or counselling for alcohol		
5	Any broken bones				34	(Women) Are you pregnant?		
6	Do you have a **problem** running 100 metres				35	Kidney or bladder disease		
7	Joint injury, pain, swelling or problem				36	Recurrent indigestion or reflux		
8	Abnormal shortness of breath				37	Stomach or duodenal ulcer		
9	Excess sleepiness, snoring or sleep apnoea				38	Vomiting blood or passing blood		
10	High blood pressure				39	Recurrent diarrhoea or dysentery		
11	Heart disease or circulation problem				40	Haemorrhoids (piles)		
12	Bronchitis, pleurisy, or persistent cough				41	Diabetes		
13	Coughing up blood				42	Jaundice, hepatitis, liver, or pancreas illness		
14	Tuberculosis (TB) or 'consumption'				43	Immune disorder or HIV		
15	Asthma				44	Malaria or any tropical disease		
16	Hay fever				45	Thyroid disorder, or goitre		
17	Other nose or throat trouble				46	Hernia, or rupture		
18	Discharging ears				47	Lump, tumour or any form of cancer		
19	Deafness				48	Foot trouble, bunions, hammer toe		
20	Do you wear glasses for reading				49	Varicose veins or leg ulcers		
21	Do you wear glasses for distant vision				50	Dermatitis, eczema, or rash		
22	Do you wear contact lenses				51	Recent unexplained weight loss		
23	Eye problem of any sort				52	Reaction to drug or injection		
24	Any paralysis (including polio)				53	Allergies		
25	Fainting attacks or blackouts				54	Strain or ganglion or tennis elbow		
26	Fits, or epilepsy of any kind				55	Any other illness or injury		
27	Severe headaches or migraine				56	Tablets or medicines in last 12 months		
28	Head injury or concussion				57	Blood test or xray in last 12 months		
29	Nervous breakdown or mental illness or anxiety or depression				58	Do you have any problem wearing safety boots or safety equipment?		

If **YES** to any of the above questions, please write the Question # and give details. Should you require more space, please attach another page.

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Health questionnaire concerning: **Applicants name** ____

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
About how often did you feel tired out for no good reason?					
About how often did you feel nervous?					
About how often did you feel nervous that nothing could calm you down?					
About how often did you feel hopeless?					
About how often did you feel restless or fidgety?					
About how often did you feel restless you could not sit still?					
About how often did you feel depressed?					
About how often did you feel that everything is an effort?					
About how often did you feel so sad that nothing could cheer you up?					
About how often did you feel worthless?					

Urine Drug screen required by referrer: Yes ☐ No ☐
I DO / DO NOT consent to undergo any drug screen test as required by the referrer.

STATEMENT

The answers I have given in this health questionnaire are true and complete. 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.

Signature of Applicant: ____ Date:

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