VALEWOOD CLINIC

ABN 66 420 561 884

FAMILY MEDICINE OCCUPATIONAL HEALTH

A: 1 Wanda Street, Mulgrave Vic 3170
T: (03) 9560 6655 (03) 9560 6510
F: (03) 9561 5317
E: staff@valewoodclinic.com.au
W: www.valewoodclinic.com.au

PRE-EMPLOYMENT MEDICAL EXAMINATION QUESTIONNAIRE

APPOINTMENT TIME: ..... **DATE :** ..../..../....

PREPARED FOR (Company Name): _____

APPLICANT: _____

DATE OF BIRTH: ..../..../....

HOME ADDRESS: _____

CONTACT TELEPHONE NUMBER: .....

OCCUPATION / PROPOSED OCCUPATION: .....

COMPANY DETAILS

NAME OF COMPANY: .....

H.R. MANAGER / CONTACT PERSON: .....

ADDRESS: .....

TELEPHONE NO: ..... **E-MAIL :** .....

Please have the applicant complete the following two pages and bring them with him/her to their appointment.

We appreciate your cooperation in helping us deliver this service in an efficient and timely manner. Please do not hesitate to contact our clinic on (03) 9560 6655 if you require any further information.

CONFIDENTIAL

>**Dr P A GILES** M.B.B.S., Dip. R.A.C.O.G., Grad.Dip.Occ.H. Prov. No. 470 581 X
>**Dr P J LACKNER** M.B.B.S., F.R.A.C.G.P., Dip.Sports Med. Prov. No. 95340 EW
>**Dr M A KILEY** M.B.,BS F.R.A.C.G.P., Prov. No. 95399 JX
>**Dr S BANSAL** M.B.B.S., F.R.A.C.G.P., Prov. No. 252 6157 A
>**Dr A HERATH** B.A.B.Sc., B.M.B.S., F.R.A.C.G.P. Prov. No. 2474348 W
>**Dr P BEVZ** M.B.B.S. 0193675 J

QIP/AGPAL
SPECIALIST IN ACCREDITATION, QUALITY AND RISK MANAGEMENT

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>**Dr J SONG** M.B.B.S., F.R.A.C.G.P., Ph.D Prov. No. 229 2627 B
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OCCUPATIONAL HISTORY

PREVIOUS EMPLOYERS	LENGTH OF EMPLOYMENT	INDUSTRY TYPE	OCCUPATION / POSITION

PERSONAL HEALTH

DO YOU CURRENTLY, OR HAVE YOU EVER, SUFFERED FROM:

1	Wheezing, asthma, bronchitis or persistent cough	☐YES	☐NO
2	Pneumonia, other lung infection, abnormal Chest X Ray	☐YES	☐NO
3	Hay fever or sinus problems	☐YES	☐NO
4	Shortness of breath, chest pain, heart trouble or rheumatic fever	☐YES	☐NO
5	Heart palpitations or murmurs	☐YES	☐NO
6	High blood pressure or elevated cholesterol	☐YES	☐NO
7	Heartburn, stomach or duodenal ulcers	☐YES	☐NO
8	Passing, vomiting or coughing up blood	☐YES	☐NO
9	Difficulty swallowing	☐YES	☐NO
10	Frequent or severe diarrhoea / abdominal pains	☐YES	☐NO
11	Hernia	☐YES	☐NO
12	Liver disease, hepatitis or gall bladder disease	☐YES	☐NO
13	Cancer, malignancy or tumour	☐YES	☐NO
14	Anaemia or other blood disorder	☐YES	☐NO
15	Blackouts, fainting attacks, dizziness	☐YES	☐NO
16	Fits, epilepsy	☐YES	☐NO
17	Migraines, or recurrent headaches	☐YES	☐NO
18	Head injury or concussion	☐YES	☐NO
19	Hearing problems, ear infections ringing/buzzing in ears	☐YES	☐NO
20	Diabetes, thyroid or other gland problems	☐YES	☐NO
21	Dermatitis, eczema, psoriasis or skin problem	☐YES	☐NO
22	Back pain, back injury or sciatica	☐YES	☐NO
23	Frequent or severe neck/shoulder pain or stiffness	☐YES	☐NO
24	Joint pain, swelling or stiffness	☐YES	☐NO
25	RSI, occupational over use syndrome	☐YES	☐NO
26	Anxiety, depression or phobias	☐YES	☐NO
27	Other mental illness or psychiatric consultations	☐YES	☐NO
28	Have you ever had an operation or serious illness?	☐YES	☐NO
29	Are you presently receiving treatment for any medical condition?	☐YES	☐NO
30	Has your weight altered significantly in the last year?	☐YES	☐NO
31	Are you allergic to anything?	☐YES	☐NO
32	Have you lost time from wrk in the last 2 years because of any illness or injury?	☐YES	☐NO
33	Have you ever had a disease or injury resulting from work?	☐YES	☐NO
34	Have you ever been exposed to loud noise at work or recreationally?	☐YES	☐NO
35	Have you ever worked with, or been exposed to, asbestos fibre?	☐YES	☐NO

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PERSONAL HEALTH (CONT'D)

ALCOHOL -	HOW MANY:	NUMBER		DAY / WEEK
			GLASSES BEER PER	

TABACCO **DETAILS:**

DO YOU CURRENTLY SMOKE: ☐YES ☐NO

HAVE YOU EVER SMOKED: ☐YES ☐NO

EXERCISE

On average, how many times a week do you exercise for at least 20 minutes hard enough to feel your heart beat, or breathe heavily?

Indicate YES where applicable:

☐YES ☐NO **Less than once**

☐YES ☐NO **1 – 2 times per week**

☐YES ☐NO **3 or more times per week**

IMMUNISATION HISTORY

TETANUS ☐YES ☐NO **DATE:** / /

HEPATITIS B ☐YES ☐NO **DATE:** / /

HEPATITIS A ☐YES ☐NO **DATE:** / /

OTHER:

The purpose of this examination and the consequent opinions expressed are in the interest of prevention of occupational injury through the proper placement of employees. Valewood Clinic is not responsible for determining the suitability or otherwise of this person's application for employment, or for the treatment of any disease or illness disclosed by is medical examination.

I declare the above to be a true statement of my medical history and I consent to the release of results to the requesting party.

SIGNED: **DATE :** / /

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