



SOUTHERN MEDICAL SERVICES PTY LTD t/a ERA HEALTH

PO Box 1055, Hawthorn. 3122.

Telephone: 03 9944 6200

Facsimile: 03 9944 6290

PRE-EMPLOYMENT MEDICAL EXAMINATION

SECTION A: To be completed by the PROSPECTIVE EMPLOYER
 SECTION B: To be completed by the APPLICANT.
 SECTION C: To be completed by the DOCTOR/NURSE.
 CERTIFICATE: To be completed by the DOCTOR.

SECTION A

TO BE COMPLETED BY PROSPECTIVE EMPLOYER

NAME OF APPLICANT: AGE: DOB:

ADDRESS: POSTCODE:

CONTACT NUMBER:

POSITION APPLIED FOR:

MANAGER TO INCLUDE JOB DESCRIPTION (this is to be reviewed by the doctor at the time of the medical)

COMMERCIAL VEHICLE DRIVERS MEDICAL REQUIRED? YES NO

NAME OF COMPANY:

DIVISION: CONTACT NAME: CONTACT NO:

TO THE DOCTOR:

Thank you for agreeing to undertake this assessment. On our behalf, would you please perform the following:

- Medical Examination
 - Chest X-ray (if clinically indicated)
 - ECG (for all applicants aged 55 years or over and/or if clinically indicated)
 - Other (please list)
 - Audiogram (hearing test)
 - Lung Function Test (spirometry)
 - Urine Drug Screen
 - Alcohol Screen (breathalyser)
-

SECTION B

TO BE COMPLETED BY THE APPLICANT

Please complete the following:

Surname		Given Names	
Date of Birth		Male	<input type="checkbox"/>
		Female	<input type="checkbox"/>
Address			
Suburb		State	Postcode
Home Phone No:	Business Phone No:		Mobile Phone No:
E-mail address:			

MEDICAL QUESTIONNAIRE

Please tick the 'NO' or 'YES' column for the questions listed below.

Have you ever had or have you now:	NO	YES	Have you ever had or have you now:	NO	YES
1. Any neck, arm or shoulder injury or problem?			20. Vomiting or passing of blood?		
2. Any back, leg or joint injury or problem?			21. Recurrent diarrhoea or dysentery?		
3. Any broken bones?			22. Diabetes, goitre or other gland trouble?		
4. Swollen or painful joints?			23. Jaundice, hepatitis or liver disease?		
5. Shortness of breath or persistent cough, pneumonia?			24. Malaria/any tropical disease?		
6. High blood pressure?			25. Hernia?		
7. Heart disease or angina?			26. Foot trouble, bunions, swollen ankles, gout?		
8. Bronchitis or pleurisy?			27. Varicose veins, ulcers?		
9. Consumption, tuberculosis?			28. Dermatitis or eczema?		
10. Asthma?			29. Reaction to drug or injection?		
11. Hayfever or other allergies?			30. Fainted in the last five years?		
12. Eye trouble, do you wear glasses or contact lenses?			31. Any other illness or injury?		
13. An injury to your eyes?			32. A blood test or x-ray in the past 12 months?		
14. Regular headaches?			33. Rheumatic fever?		
15. Fits/epilepsy?			34. Frequent colds, sore throats?		
16. Sleep disturbance, anxiety or depression?			35. An ear infection, injury, rupture of ear drum or deafness?		
17. Mental illness/nervous breakdown?			36. Ringing or noises in the ears?		
18. Kidney or bladder trouble including stones?			37. Hearing test?		
19. Recurrent indigestion, ulcer of stomach or duodenum?			38. (Women) Are you pregnant?		

Alcohol

	No	Yes
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever felt that you should cut down on your drinking?	<input type="checkbox"/>	<input type="checkbox"/>
Have people annoyed you by criticising your drinking?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever felt bad or guilty about your drinking?	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever have a drink first thing in the morning to steady you or help a hangover?	<input type="checkbox"/>	<input type="checkbox"/>

Smoking history

	Yes	No
Have you ever smoked at least 1 cigarette/day or 1 cigar/week or 50 g pipe tobacco/month for at least one year?	<input type="checkbox"/>	<input type="checkbox"/>
Do you currently smoke?	<input type="checkbox"/>	<input type="checkbox"/>

If you are a current smoker, what do you usually smoke?

	Yes	No	How many per day on average
Manufactured cigarettes	<input type="checkbox"/>	<input type="checkbox"/>	[[]
Hand-rolled cigarettes	<input type="checkbox"/>	<input type="checkbox"/>	[[]
Pipe	<input type="checkbox"/>	<input type="checkbox"/>	[[]
Cigars	<input type="checkbox"/>	<input type="checkbox"/>	[[]

If you are a past smoker, in which year did you stop smoking?

[[[[[]

Work History

Please list your employment history over the last 10 years

Employer	Dates (from – to)	Type of Work	Reason for Leaving

Name of your general practitioner (GP):

Address:

Phone:

AUTHORITY REGARDING MEDICAL INFORMATION

I consent to a medical examination and if required urine drug test, chest x-ray, ECG and other investigations that are clinically indicated in relation to my application for employment. I declare that the information which I have set out in this questionnaire is truthful, and that there are no false or misleading answers or omissions.

I understand that if I do not disclose the above information, or if I make a false or misleading disclosure, then I may not be entitled to compensation under the relevant state and/or federal accident / rehabilitation / WorkCover legislation for any reoccurrence, aggravation, acceleration, exacerbation, or deterioration of a pre-existing injury or disease arising out of or in the course of or due to the nature of any employment with my proposed employer. Further, I understand that any false or misleading information may result in termination of employment.

I authorise the doctors and or nurses from Southern Medical Services (t/a Era Health) and/or its medical agents to contact any person, clinic or hospital which has previously provided me with treatment in order to obtain further medical information which may assist them in determining my suitability for the job for which I have applied.

Please tick or cross ONE box only:

- I consent to the content and results of this examination being released to my prospective employer, to assess my suitability for the position for which I have applied.
- I consent to the Certificate of Examination only (ie. last page of this documentation) being released to my prospective employer, to assess my suitability for the position for which I have applied.

Signed:

Witness: Date:

The examining doctor wishes to make it known that the purpose 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 the employment.

Patient proof of identity (to be completed by the doctor):

- Photo driver’s licence
- Passport
- Other

Passport/Licence No:

SECTION C

TO BE COMPLETED BY THE DOCTOR/NURSE

APPLICANT'S SURNAME: OTHER NAMES:

BUILD/APPEARANCE	<input type="checkbox"/> Slender	<input type="checkbox"/> Medium	<input type="checkbox"/> Heavy	<input type="checkbox"/> Obese																																				
HEIGHT:..... cm	WEIGHT:kg	BMI:.....																																						
URINE ANALYSIS	Albumen	Sugar	Blood	Other																																				
VISUAL ACUITY	GLASSES <input type="checkbox"/> WORN	DISTANCE <input type="checkbox"/>	NEAR <input type="checkbox"/>	BIFOCAL <input type="checkbox"/> CONTACT LENSES <input type="checkbox"/>																																				
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B.P.(seated)	Second B.P reading if necessary	Pulse	Rhythm.....																																					
AUDIOMETRY (if indicated or required – attach graph)		SPIROMETRY (if indicated or required – attach report)																																						
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		TEST NORMAL YES/NO																																						

DRUG AND ALCOHOL TESTING (if required) – attach report

- Taken Not taken
 Normal Abnormal

LIFTING ASSESSMENT (if required): *Lift a 15kg weight from floor to waist height*

- Ability** Able Has difficulty, please comment
- Technique** Satisfactory Unsatisfactory Advice given if unsatisfactory

CHEST X-RAY (if required) - attach report

- Taken Not taken
 Normal Abnormal

ECG (if required or indicated) – attach report

- Taken Not taken
 Normal Abnormal

OTHER TEST/INVESTIGATIONS (if required) – please attach report and comment on the report whether normal or abnormal

- Not requested
 Requested Results attached Awaiting Results

PHYSICAL EXAMINATION			
IF NOT EXAMINED ENTER 'NE'	NORMAL	ABNORMAL	DOCTOR'S COMMENTS (Please comment on all abnormalities)
1. Head, face, neck, scalp			
2. Nose			
3. Mouth, throat, speech			
4. Teeth, gums			
5. Ears (inc drums)			
6. Eyes general (inc cataract)			
7. Eyes ocular motility			
8. Eyes ophthalmology (if indicated)			
9. Chest shape			
10. Auscultation			
11. Symmetrical chest expansion			
12. Clubbing			
13. Heart			
14. Veins/Varicose Veins			
15. Peripheral pulses			
16. Peripheral oedema			
17. Abdomen (inc hernial orifices)			
18. Genito urinary system			
19. Skin			
20. Scars			
21. Cubital fossa scars			
22. Nervous system			
23. Minor/major psychiatric condition			
24. Behaviour during examination			
MUSCULOSKELETAL SYSTEM			
25. Posture			R = L=
26. Gait			
27. Able to squat			
28. Squat walk			
29. Walk on heels and toes			
30. Straight leg raise			
31. Scoliosis			
32. Grip strength			
33. Flat feet			
Range of movement			
34. Cervical spine			
35. Lumbar spine			
36. Shoulders			
37. Elbows			
38. Wrists			
39. Fingers			
40. Hips			
41. Knees			
42. Feet and ankles			
Reflexes			

43. Knee			
44. Ankle			
45. Biceps			
46. Triceps			
47. Rhomberg			

Does the applicant suffer from any conditions that are currently active? Yes No
 If 'yes', please list below:-

Was it necessary to refer the applicant to their GP or a specialist for follow-up of a medical condition?
 Yes No

If 'yes', please list details below:-

Following this examination, the applicant:-

- is considered to be medically suited for the position applied for.
- or
- is considered to be medically suited for the position applied for with the following restrictions:-

.....

- or
- is **NOT** considered to be medically suited for the position applied for.

Signature of Medical Examiner: Date:

CERTIFICATE OF EXAMINATION

This is to certify that

was examined on / /

for the purpose of assessing suitability to work as

and

- is considered to be medically suited for the position applied for.
- is considered to be medically suited for the position applied for with the following restrictions:-

.....
.....

- is **NOT** considered to be medically suited for the position applied for.

Examining doctor's name..... (please print or use stamp)

Signature:

Date:

Please return a copy of all forms by either post or facsimile to:

Southern Medical Services Pty Ltd
PO Box 1055
Hawthorn 3122

Facsimile: 03 9944 6290