# Pre Employment Health Questionnaire

## ADVICE FOR PROSPECTIVE EMPLOYEES

**You are about to complete a Pre-Placement Health Questionnaire**.

Are you in any way aware of any pre-existing injury or disease that may be affected by the nature of the proposed job? If so, please detail this on the questionnaire. You are also required to complete the Employee Declaration of pre-existing injury.

If you fail to disclose or make a false or misleading disclosure, any recurrence, aggravation, acceleration, exacerbation or deterioration of the pre-existing injury/disease may not entitle you to compensation.

The Pre-Placement questionnaire and medical examinations relate to the inherent requirements of the position applied for, and only assess current ability to perform the related duties whilst satisfying Occupational Health and Safety obligations. Results are used to assist with determining suitability to the position applied for, and are not the sole criterion used to make employment decisions.

Additionally, in the event of a medical examination being required, the medical assessment involves the assessment of the functions of parts of the body relevant to the position for which you have applied. You may also be required to undergo a drug or alcohol screening test.

The questionnaire and tests do not attempt to predict future deterioration, nor discriminate against people with disabilities, impairment or illnesses. Ways of accommodating people without all required physical attributes will be considered in determining suitability.

The questionnaire and medical test results are confidential records.

These will be maintained by Power Projects International and the relevant medical service provider, and will not be released to other parties without the consent of the employee unless otherwise required by law.

If you have any objection to completing a pre employment health questionnaire and, if determined as necessary, a pre-placement medical examination, please advise the interviewer.

**Pre-Employment Health Questionnaire*(CONFIDENTIAL)***

## Applicant Consent:

I _____ hereby consent to undertaking a pre-placement health questionnaire and, if deemed necessary, undertaking a Pre Employment Medical Assessment with a nominated service provider. I further declare that the information I provide will be a true and correct account of my past and present medical history. I authorise the examining professional to make a recommendation to my prospective employer as to my suitability for the position. As a prospective employee, I understand that any incorrect or misleading statements or omissions may render me ineligible for appointment.

I also authorise the nominated medical assessor to contact my personal doctor for further information if required for the purposes of this health questionnaire.
My personal doctor's details are:

| | |
|---|---|
| Doctor's Name: | |
| Doctor's Telephone Number: | |

## Applicant Information

You are about to undergo a remote pre-placement questionnaire/medical assessment.
Are you in any way aware of any pre-existing injury or disease that may be affected by the nature of the proposed job? Please tick the appropriate box.

YES ☐ NO ☐

If you answered "yes", please providedetails: _____

_____

_____

_____

Reminder: If you fail to disclose or make a false or misleading disclosure, any recurrence, aggravation, acceleration, exacerbation or deterioration of the pre-existing injury/disease may not entitle you to compensation.

| 1.MEDICAL HISTORY | | | |
|---|---|---|---|
| MEDICAL CONDITION | YES | NO | DETAILS |
| 1. Cancer, Tumor | | | |
| 2. Varicose Veins, Blocked Arteries, Clots, Blood Disorder | | | |
| 3. Hernia | | | |
| 4. Blackouts, Fits, Faints, Epilepsy, Spasms, Dizziness, Giddiness | | | |
| 5. Persistent or Severe Headaches, Migraines | | | |
| 6. Head Injury, Brain Injury, Concussion | | | |
| 7. Arthritis, Rheumatism, Other Joint Illnesses | | | |
| 8. Hepatitis, Jaundice | | | |
| 9. Stomach Ulcers, Indigestion, Pancreatitis, Bowel Problems, Other Abdominal Disorders | | | |
| 10. Kidney Problems, Overactive or Underactive Thyroid Gland, Bladder Problems | | | |
| 11. Nervous Disorder, Claustrophobia, Depression, Anxiety, Other Stress Related Disorders | | | |
| 12. Eczema, Psoriasis, Dermatitis, Other Skin Disorders | | | |
| 13. Diabetes, High Cholesterol | | | |
| 14. Liver Disease | | | |
| 15. Prostate Problems, Hysterectomy, Pregnancy | | | |
| 16. Congenital Defects/Disorders | | | |
| 17. Degenerative diseases/disorders | | | |

| 2. GENERAL HEALTH | | | |
|---|---|---|---|
| HEALTH RELATED QUESTIONS | YES | NO | DETAILS |
| 1. Does any health problem restrict your activities of daily living? | | | |
| 2. Have you lost or gained weight in the past 6 months? If so, how much? | | | |
| 3. Do you have any allergies (e.g., hayfever, food products, chemicals or medication)? | | | |
| 4. Do you suffer from any condition that requires regular medical review or time away from work for treatment or rest? | | | |
| 5. Do you have any communicable disease (e.g., hepatitis A, B, C, HIV/AIDS) or problem that may impair your ability to perform the job you are applying for or may affect other co-workers? | | | |
| 6. Have you ever been regularly exposed to any hazards such as: Chemicals / Noise / Heavy metals / Asbestos /Radiation / Other? | | | |
| 7. Do you suffer from any condition that may cause drowsiness or impair your concentration? | | | |
| 8. Is there any medical or health reason that would prevent you from working shift work? | | | |
| 9. Do you see your doctor regularly? | | | |
| 10. Has your doctor advised you against taking any employment because it may put you at risk? | | | |

| 3. RESPIRATORY FUNCTION | | | |
|---|---|---|---|
| HEALTH RELATED QUESTIONS | YES | NO | DETAILS |
| 1. Have you ever suffered from:<br>· Asthma<br>· Bronchitis<br>· Pneumonia<br>· Pleurisy<br>· Emphysema<br>· Tuberculosis<br>· Industrial Lung Disease<br>· other respiratory disorders? | | | |
| 2. Do you experience shortness of breath when resting? | | | |
| 3. Do you experience shortness of breath with minimal exercise such as walking up a slight hill? | | | |
| 4. Do you ever wake during the night with shortness of breath or a wheeze? | | | |
| 5. Do you usually cough a lot first thing in the morning? | | | |
| 6. Do you usually bring up phlegm from your chest any time of the day or night? | | | |
| 7. Have you ever had attacks of shortness of breath or wheezing? | | | |
| 8. Does your chest ever feel tight or your breathing become difficult? | | | |
| 9. Have you ever been exposed to disturbed asbestos, coal or silica? | | | |

| 4. CARDIOVASCULAR FUNCTION AND PHYSICAL ACTIVITY | | | |
|---|---|---|---|
| HEALTH RELATED QUESTIONS | YES | NO | DETAILS |
| 1. Have you ever suffered from:<br>• Heart Disease<br>• Heart Attack<br>• Stroke<br>• High Blood Pressure<br>• Heart Palpitations<br>• other heart illnesses | | | |
| 2. How often do you exercise for 20 minutes or more?<br>Never □ 1-2x per week □ >3x per week □ | | | Types of exercise: |
| 3. Has your doctor ever said that you have a heart condition? | | | |
| 4. Has your doctor ever said that you should only engage in physical activity recommended by a doctor? | | | |
| 5. Is your doctor currently prescribing drugs (e.g., aspirin) for your blood pressure or heart condition? | | | |
| 6. Do you ever feel pain in your chest when you engage in physical activity? | | | |
| 7. Do you lose your balance because of dizziness, or do you ever lose consciousness when engaging in physical activity? | | | |
| 8. Do you know of any other reason why you should not engage in physical activity? | | | |

| 5. HEARING | | | |
|---|---|---|---|
| HEALTH RELATED QUESTIONS | YES | NO | DETAILS |
| 1. Have you ever had exposure to explosives or gunfire? | | | |
| 2. Have you ever worked in the Military Service? | | | Years of service: |
| 3. Do you have a history of hearing troubles? | | | |
| 4. Did you take antibiotics during childhood? | | | |
| 5. Have you ever engaged in any noisy hobbies (e.g., motorbike riding, carpentry)? | | | |
| 6. Have you ever worked in a noisy environment including working with power-tools? | | | |
| 7. Do you experience dizziness? | | | |
| 8. Do you experience ringing in your ears? | | | |
| 9. Do you suffer from frequent colds? | | | |
| 10. Do you experience discharges from your ears? | | | |
| 11. Have you experienced mumps/measles? | | | |
| 12. Have you ever been diagnosed with industrial deafness? | | | |

| 6. DRUGS AND MEDICATION | | | |
|---|---|---|---|
| HEALTH RELATED QUESTIONS | YES | NO | DETAILS |
| 1. Are you a current smoker or ex-smoker | | | Current cigarettes per day: |
| 2. Do you consume alcohol? | | | Alcoholic drinks per day / per week: |
| 3. Are you currently taking any prescription medication? | | | Type: |
| 4. Are you currently taking any non-prescription medication or remedies? | | | Type: |

| 7. MUSCULOSKELETAL HISTORY | | |
|---|---|---|
| NECK | YES | NO |
| Have you ever injured or experienced pain in your neck? | | |

If YES to any of the above, please answer the following:

Approximate date occurred _____

Consulted a medical practitioner? Yes ☐ No ☐

Resulted in time off work? Yes ☐ No ☐

Surgery required? Yes ☐ No ☐

Ongoing problems? Yes ☐ No ☐

*Additional info:*

| BACK | YES | NO |
|---|---|---|
| Have you ever injured or experienced pain in your back? | | |

If YES to any of the above, please answer the following:

Approximate date occurred _____

Consulted a medical practitioner? Yes ☐ No ☐

Resulted in time off work? Yes ☐ No ☐

Surgery required? Yes ☐ No ☐

Ongoing problems? Yes ☐ No ☐

*Additional info:*

Have you ever injured or experienced pain in your shoulders, elbows, wrists or hands? i.e. sprain / strain / fracture / tendonitis / epicondylitis / carpal tunnel syndrome etc. Indicate by ticking boxes below.

| SHOULDER | YES | NO | ELBOW | YES | NO | WRIST | YES | NO | HANDS | YES | NO |
|---|---|---|---|---|---|---|---|---|---|---|---|

If YES to any of the above, please answer the following:

Approximate date occurred _____

Consulted a medical practitioner? Yes ☐ No ☐

Resulted in time off work? Yes ☐ No ☐

Surgery required? Yes ☐ No ☐

Ongoing problems? Yes ☐ No ☐

*Additional info:*

Have you ever injured or experienced pain in your hips, knees, ankles or legs? i.e. sprain / strain / fracture / tendonitis etc. Indicate by ticking boxes below.

| HIPS | YES | NO | KNEES | YES | NO | ANKLES | YES | NO | LEGS | YES | NO |
|---|---|---|---|---|---|---|---|---|---|---|---|

If YES to any of the above, please answer the following:

Approximate date occurred _____

Consulted a medical practitioner? Yes ☐ No ☐

Resulted in time off work? Yes ☐ No ☐

Surgery required? Yes ☐ No ☐

Ongoing problems? Yes ☐ No ☐

*Additional info:*

| 8. FUNCTION HISTORY | | |
|---|---|---|
| ACTIVITIES | YES | NO |
| 1. Do you have any pain or discomfort when lifting or handling heavy objects? | | |
| 2. Do you have any knee pain when squatting or kneeling? | | |
| 3. Do you have any back pain when bending forward or twisting? | | |
| 4. Do you have any pain or difficulty when lifting objects above your shoulder height? | | |
| 5. Do you have any pain when doing any of the following for PROLONGED PERIODS*(please circle appropriate response)*<br>Walking Yes / No Standing Yes / No<br>Sitting Yes / No Squatting Yes / No<br>Climbing Yes / No Kneeling Yes / No<br>Bending Yes / No | | |
| 6. Do you have any pain when working with hand tools? | | |
| 7. Do you experience any difficulty operating machinery? | | |
| 8. Do you have any difficulty operating computer instruments? | | |
| 9. Do you have any problems working in:<br>• Hot dry conditions?<br>• Humid conditions?<br>• Cold conditions?<br>• Wet conditions? | | |
| 10. Do you have problems working at heights? | | |
| 11. Do you have difficulties traveling in a vehicle for longer than 20 minutes at a time? | | |
| 12. Is there any reason why you cannot wear safety or protective equipment (e.g., safety boots, ear muffs or plugs, gloves, safety glasses or hard hat)? | | |
| 13. Do you anticipate that you will require assistance, in the form of specific aids or task modification, in order to undertake the essential components of the job applied for? | | |
| If YES to any of the above, please explain : | | |

## DECLARATION AND INFORMATION CONSENT

1. Do you have any other medical, physical or health problems that you have *not* outlined within this questionnaire?

   YES / NO (please circle)

   If YES, please provide details: _____

   _____

2. Do you foresee experiencing any physical, medical or health related difficulties performing the position you are applying for?

   YES / NO (please circle)

   If YES, please provide details: _____

   _____

3. Do you foresee experiencing any physical, medical or health related difficulties undertaking the Pre-Employment Assessment?

   YES / NO (please circle)

   If YES, please provide details: _____

   _____

4. I declare that the answers and information given in this questionnaire are true and correct to the best of my knowledge and I have not willingly omitted any information.

Printed Name: _____

Signed: _____

Date: _____

***Thank you.***