Doctors on Riccarton
Helping you to better health

Pre-Employment Health Assessment

183 Riccarton Road, Christchurch 8041 Ph: 03 348 8989 Fax: 03 348 8618

Applicant Name: _____ **DOB:** _____

Location: _____ **Sex:** F ☐ M ☐

Position Applied for: _____

Position Activities: _____

MEDICAL HISTORY

1. What is your general state of health? Very good ☐ Good ☐ Fair ☐

2. Are you receiving any medical treatment or medication at present or have you received medical treatment in the last five years? Yes ☐ No ☐

2a. If Yes, for what condition/s:

_____

_____

3. Have you ever suffered any work-related injuries or conditions, etc.? Yes ☐ No ☐

Year _____ Injury/Condition _____

Year _____ Injury/Condition _____

Year _____ Injury/Condition _____

4. Have you suffered any other injuries/conditions that required medical treatment? Yes ☐ No ☐

4a. If Yes, what and when?

_____

_____

5. Do you wear glasses/contact lenses? Yes ☐ No ☐

6. Have you ever worked in a noisy environment or an environment where you have been required to wear hearing protection? Yes ☐ No ☐

Noise Exposure History:		(Years / Months)	
	Present Occupation		
	Secondary Employment		
	Previous Employment		
	Military Service		
	Noisy Hobbies		

HEARING HEALTH HISTORY Details:

Diseases affecting hearing: Yes ☐ No ☐ _____

Ear or Head Injuries: Yes ☐ No ☐ _____

Family History of Hearing Loss: Yes ☐ No ☐ _____

Recent Ear Ache or Discharge: Yes ☐ No ☐ _____

Have you a Hearing Loss?: Yes ☐ No ☐ _____

Other Comments: _____

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7. Have you ever been refused life insurance or a job because of poor health? Yes ☐ No ☐

8. Any family history of major illness like diabetes, heart disease, epilepsy etc? Yes ☐ No ☐

, On average, how many times a week do you do exercise?

Less than once ☐ 1 to 2 ☐ At least 3 ☐

Describe activity: _____

10. Do you drink alcohol? Yes ☐ No ☐

No. of years: _____ Standard drinks per week: _____

(1 drink = 250ml beer, 125ml wine or 30ml liquor)

11. Do you smoke? Yes ☐ No ☐ Ex-smoker ☐

What types: Cigarette ☐ Cigars ☐ Pipe ☐

No. of years: _____ No. per day: _____

12. Have you ever had (tick box if Yes):

Epilepsy, fits, fainting attacks	☐	Rheumatism, arthritis, joint disease	☐
Paralysis or stroke	☐	Hernia	☐
Mental illness, depression, nervous breakdown	☐	Neck and back problem	☐
High blood pressure or heart problem	☐	Tendinitis, tenosynovitis, RSI	☐
Asthma, TB, pneumonia or any chest condition	☐	Cancer of any kind	☐
Peptic ulcer, hepatitis, pancreatitis, bowel disease	☐	Any skin disorder	☐
Varicose veins	☐	Allergy to medication or chemicals	☐
Hearing, speech and sight changes	☐	Any infectious disease	☐
Diabetes, kidney or thyroid trouble	☐	Any operations	☐
Any Gynaecological problems	☐	Others	☐

If yes, please write details:

_____

13. Have you had any of the following vaccinations:

Tetanus (ADT)	Yes ☐	Date:	_____	No ☐
Hepatitis A	Yes ☐	Date:	_____	No ☐
Hepatitis B	Yes ☐	Date:	_____	No ☐
BCG	Yes ☐	Date:	_____	No ☐
Other:		Date:	_____	

Declaration:

The information given above by me to the medical examiner is correct and honest to the best of my knowledge. I also agree to release any of this information in the report to my prospective employer if necessary.

Signature	**Date**

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PHYSICAL EXAMINATION

Height: _____ cm Weight: _____ kgs BMI (Body Mass Index) _____

Urinalysis:

Protein	Yes ☐	No ☐
Blood	Yes ☐	No ☐
Sugar	Yes ☐	No ☐
Drugs Detected	Yes ☐	No ☐

1. SKIN

Any evidence of eczema/dermatitis or other skin disorder? Yes ☐ No ☐

If yes, describe: _____

2. EARS

	LEFT		RIGHT	
Otitis Externa	Yes ☐	No ☐	Yes ☐	No ☐
Otitis Media	Yes ☐	No ☐	Yes ☐	No ☐
Perforation of eardrum	Yes ☐	No ☐	Yes ☐	No ☐
Scarred eardrum	Yes ☐	No ☐	Yes ☐	No ☐

Audiogram

Hearing Loss (**Audiogram** report attached) _____ % _____ %

3. EYES

Colour Vision: Normal ☐ Abnormal ☐

Vision:		LEFT	RIGHT
Distance:	Without Glasses	/	/
(Snellen chart)	With Glasses	/	/
Near:	Without Glasses	Normal ☐ Abnormal ☐	Normal ☐ Abnormal ☐
	With Glasses	Normal ☐ Abnormal ☐	Normal ☐ Abnormal ☐

4. CARDIOVASCULAR SYSTEM

Pulse Rate: _____ /min Regular ☐ Irregular ☐

Character: Normal ☐ Abnormal ☐ Details: _____

Blood Pressure: _____ / _____ mmHg

Abnormal Heart Sound: Yes ☐ No ☐ Details: _____

Ankle oedema: Yes ☐ No ☐

Varicose veins: Left Leg ☐ Right Leg ☐

5. RESPIRATORY SYSTEM

Thyroid enlargement: Yes ☐ No ☐

Neck glands: Normal ☐ Abnormal ☐

Chest Clear: Yes ☐ No ☐

Air entry: Normal ☐ Reduced ☐ Left ☐ Right ☐

Mini Spirometry:

Fev1	Fvc	Fev1/Fvc	Pevr

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6. GASTRO-INTESTINAL SYSTEM

Mouth:	Normal ☐	Abnormal ☐	Details _____
Tongue:	Normal ☐	Abnormal ☐	Details: _____
Throat:	Normal ☐	Abnormal ☐	Details: _____
Abdominal scar:	Yes ☐	No ☐	Details: _____
Hernia:	Yes ☐	No ☐	Site: _____

7. NERVOUS SYSTEM

Sensation:	Normal ☐	Abnormal ☐	Details: _____
Tremor:	Yes ☐	No ☐	Site: _____

8. MUSCULOSKELETAL SYSTEM

Spine	Normal ☐	Abnormal ☐	
Scar:	Yes ☐	No ☐	
Range of Movement:			
Cervical spine:	Normal ☐	Abnormal ☐	Details: _____
Thoracic spine:	Normal ☐	Abnormal ☐	Details: _____
Lumbar spine:	Normal ☐	Abnormal ☐	Details: _____
Tenderness along the spine:	Yes ☐	No ☐	Site: _____

Arms

Any deformity, tenderness or limitation of movement:

Shoulder:	Yes ☐	No ☐	Details: _____
Elbows:	Yes ☐	No ☐	Details: _____
Wrists:	Yes ☐	No ☐	Details: _____
Hands:	Yes ☐	No ☐	Details: _____

Legs

Any deformity, tenderness or limitation of movement:

Hips:	Yes ☐	No ☐	Details: _____
Knees:	Yes ☐	No ☐	Details: _____
Ankles:	Yes ☐	No ☐	Details: _____

Any comments or other abnormalities detected on examination:

_____

_____

_____

_____

9. URINE DRUG SCREEN (see report attached)

10. ALCOHOL BREATH TEST

Result Negative:	☐	(0.00g/100mL)
Result Positive:	☐	(g/100mL)

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This page is to be sent to the prospective employer upon completion of the medical assessment. Please also send the full report to the Company contact detailed below.

The examining doctor / registered nurse has examined the person nominated above and considers him/her:

☐ FIT to perform the required duty.

☐ FIT to perform the required duty but the following is recommended:

_____

_____

☐ UNFIT to perform the required duty because:

☐ 1. Risk of injuring other workers.

☐ 2. Risk of injuring himself / herself.

☐ 3. Inability to carry out work.

However, he / she would be able to carry out the work if the following service or facilities were made available:

_____

_____

☐ UNABLE to assess because:

☐ 1. Applicant unwilling to provide information.

☐ 2. Applicant unable to provide information.

☐ 3. Further tests or information is required.

☐ If prospective employer is willing to go ahead, please send applicant back for further assessment.

The examining doctor / registered nurse wishes to make it known that the purpose of this examination and the consequent recommendation expressed is to assess the physical capabilities for the required position and in the interest of prevention of industrial injury. The success of this person's application for employment is determined by the employer.

Name of Examining Doctor / Registered Nurse: _____

Signature	**Date**