



1. PERSONAL DATA

Name:		Date of Birth:
Email Address:		Ethnicity:
Phone Numbers:	Home:	Mobile:
Address:		
Job Role:		



2. CURRENT MEDICAL PROVIDER

Name of doctor:	Phone Number: () -
Address:	



3. REVIEW OF SYMPTOMS

Do you have any of the following?	Yes	No	Do you have any of the following?	Yes	No
Weight loss / Weight gain (circle)	☐	☐	Palpitations or skipped beats	☐	☐
Fevers	☐	☐	Chest pain or tightness	☐	☐
Headaches	☐	☐	Indigestion/heartburn	☐	☐
Difficulty with vision / Wear lenses or glasses	☐	☐	Abdominal pain	☐	☐
Dizziness / Vertigo	☐	☐	Diarrhea/constipation	☐	☐
Difficulty hearing	☐	☐	Seasonal allergies	☐	☐
Sinus problems	☐	☐	Kidney stones	☐	☐
Tiredness or falling asleep during the day	☐	☐	Back pain	☐	☐
Unable to tolerate heat or cold	☐	☐	Joint pain or swelling	☐	☐
Shortness of breath with or without exertion	☐	☐	A history of broken bones	☐	☐
Wheezing / Cough	☐	☐	Swelling of the legs	☐	☐



4. CURRENT MEDICAL CONDITIONS

Those that you are currently experiencing and/or receiving treatment for (such as diabetes, high blood pressure, migraine)

	Please List	Date of onset (mo/yr)		Please List	Date of onset (mo/yr)
1		/	3		/
2		/	4		/



5. PAST MEDICAL CONDITIONS

Those that you have had in the past but have recovered from (such as childhood asthma, gestational diabetes)

	Please List	Date of onset (mo/yr)
1		/
2		/



6. SURGERIES / HOSPITALIZATIONS

List type of surgery (such as gall bladder) or condition for which you were hospitalized (such as heart attack, pneumonia)

	Please List	Date (mo/yr)
1		/
2		/



7. CURRENT MEDICATIONS (if any)

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8. OCCUPATIONAL ASSESSMENT

Please answer the following questions regarding the job for which you have been hired:

	Yes	No	Unsure
Will you be required to wear respiratory protection (e.g., N95 mask or cartridge respirator)?	☐	☐	☐
Will you be required to move heavy objects regularly (i.e., greater than 20 kg frequently)?	☐	☐	☐
Will you be required to drive a vehicle for any reason, other than to get to and from work?	☐	☐	☐
If your job involves work at a computer, have you had or are you experiencing any discomfort, pain, or numbness when working at your desk?	☐	☐	☐
Have you ever had a worker's comp claim or any work-related illness or injury?	☐	☐	☐

If yes, please give details:

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9. PLEASE READ THE FOLLOWING AND SIGN WHERE INDICATED

Important notice – workers compensation: "section 79 of the workers compensation and assistance act (1981) gives the workers compensation board discretion to refuse to award compensation, which would otherwise be payable, where it is proved that the worker has, at the time of seeking or entering employment, willfully and falsely represented himself as not having previously suffered from the disability, the subject of the claim for workers compensation."

Declaration – I solemnly declare that every answer above is true to the best of my knowledge and belief. I understand that any false or misleading information may result in termination of employment. I understand that I may also be required to undergo a hearing test on termination of employment.



10. STATEMENT AUTHORISATION

I hereby authorise the examining doctor to submit a medical report regarding the above statement, physical findings, audiogram and all other investigations to my employer or their nominated representative.

Signature of employee: _____ Date: _____