hakea GROVE

PRE EMPLOYMENT
MEDICAL QUESTIONAIRE

This form allows us to obtain relevant medical information so we can ensure, as much as possible, that you are a suitable physical and medical match for the role for which you are applying and can carry out the role without the risk of harm to yourself or others. Please note it is discriminatory to deny a person employment solely because they have a disability or illness, and that is not the intention of this questionnaire.

IMPORTANT INFORMATION

- If you are having any difficulties with any of the questions in this form, please discuss them with your treating Doctor.
- All details provided in this form are strictly confidential.

PERSONAL DETAILS	
First Name:	Last Name:
Address:	
Telephone:	Date of Birth:
Treating Doctor:	Contact Details:
Position applying for:	

MEDICAL DETAILS			
		YES	NO
1:1	Are you currently receiving any medical treatment for any illness, injury or medical condition?		
1:2	Do you have any pre-existing chronic long term injuries or illness?		
1:3	Have you been hospitalised or had any operations?		
1:4	Are you taking any medications that could impact on your ability to work?		
1:5	Have you had any prolonged time off work in the last year due to injury or illness?		
1:6	Do you have a current Workers Compensation claim?		
1:7	Have you had a Workers Compensation claim or work related illness in the past?		
Known allergies:			
If you have answered YES to any of the medical questions, please provide details bellow (include year of onset, treatment and current status of condition)			

Question Number	Details

Please tick (√) in the box beside any condition that you have now or have had at any time in your life

	Back Pain/injury		Blood pressure		Arthritis/Rheumatism
	Neck pain/injury		Asthma/lung problems		Angina/Heart trouble
	Shoulder pain/injury		Tuberculosis		Speech impairment
	Wrist pain/injury		Hernia		Anxiety/Depression
	Knee pain/injury		Seizures/blackouts		Diabetes
	Loss of hearing/Tinnitus		Infectious disease		Visual impairment
	Joint problems/fractures		Dizziness/fainting		Dermatitis/skin trouble
	Migraine/persistent headache		Hepatitis/Jaundice		Mental/nervous trouble
	Repetitive strain injury		Blood pressure		Arthritis/Rheumatism

Please comment bellow on those you have ticked:

....

Please tick (√) in the box beside any activities that you have trouble with:

	Crouching/bending		Walking
	Standing for up to 30 mins		Walking up or down stairs
	Reaching above shoulder height		Sitting for up to 30 mins
	Wearing personal protective equipment		Shift work
	Reaching between floor and waist		Frequent pushing/pulling
	Fine manipulation skills		Walking
	Crouching/bending		Walking up or down stairs
	Standing for up to 30 mins		Sitting for up to 30 mins
	Reaching above shoulder height		Shift work

Please comment bellow on those you have ticked:

....

IMMUNISATION STATUS	Yes	No	Date
Hepatitis B			
Fluvax (Influenza)			
Measles, Mumps, Rubella (MMR)			
dTpa (Diptheria, Tetanus, Pertussis)			
Varicella (Chickenpox)			
Covid-19 Vaccination	**Yes**	**No**	**Date**
DOSE 1			
DOSE 2			
DOSE 3 (Booster)			

All adults born during or since 1966 should have evidence of either receiving 2 doses of MMR vaccine or having immunity to measles, mumps and rubella. Adults born before 1966 are considered to be immune due to extensive measles, mumps and rubella circulating widely in the community during. Adults with no reliable history of chickenpox disease can have a blood test to check their immunity and if they are not immune, they can purchase it with a prescription.

To the best of my knowledge, the information I have provided in this application is true and correct. I understand that any information that is later discovered to be incorrect may result in the termination of any agreements made.

Signature:..**Date:**...