PRE EMPLOYMENT HEALTH ASSESSMENT

MEDICAL QUESTIONNAIRE:

*All prospective employees are required to undertake a pre-employment health assessment and questionnaire. This is a non-discriminatory self-administered questionnaire and asks about your employment history, general health, and fitness and well-being. It is used to assess your suitability for the role you have applied for. Please answer **every** question. Please read and sign the declaration at the end. All information is confidential and stored securely in a locked medical file.*

I, _____ *, the below named applicant, consent to the release of any health information from this pre-employment questionnaire to Tomago Aluminium Health Services staff, the visiting medical officer and HR.*

_____ _____

Signature *Date*

_____ _____

Signature (Witness/Parent if U18) *Date*

PERSONAL DETAILS:

Family Name: _____ Given Name: _____

Date of Birth: _____ Age _____ Gender: Male ☐ Female ☐

Proposed Occupation: _____

EMPLOYMENT HISTORY: (Most recent or current employer first)

From: _____ To: _____ From: _____ To: _____

Job: _____ Job: _____

Have you previously undertaken a pre-employment assessment for Tomago Aluminium? Yes ☐ No ☐

Have you previously worked in the same work environment as the role you are applying for? Yes ☐ No ☐

If Yes, were there any health issues at the time? _____

Are you aware of anything which could prevent you from working in the following situations:

Dusty environments	Yes ☐	No ☐		Day or Night Shift	Yes ☐	No ☐	
Noisy environments	Yes ☐	No ☐		Previous issue with fatigue	Yes ☐	No ☐	
Hot / humid environments	Yes ☐	No ☐		Around molten metal	Yes ☐	No ☐	
At heights	Yes ☐	No ☐		Manual and/or repetitive lift	Yes ☐	No ☐	
In confined spaces	Yes ☐	No ☐		Push / pull of loads	Yes ☐	No ☐	
Climb Stairs / ladders	Yes ☐	No ☐					

Are you fully able and prepared to wear / use all required personal protective equipment (PPE) (eg. Woollen clothing, hard hat, eye and ear protection, gloves, safety boots and respirator) Yes ☐ No ☐

Are you fully able and prepared to be clean shaven for the purpose of obtaining an adequate face seal when required to wear the appropriate respiratory protection Yes ☐ No ☐

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GENERAL HEALTH:

Have you ever had an operation or been admitted to hospital?				Yes		No
Have you ever had a motor vehicle/bike accident which caused you injury?				Yes		No
Have you ever had a sport or recreational injury?				Yes		No
If Yes to any of above:						
When		Period off work?		Yes		No
If Yes, how long?		Return to normal duty?		Yes		No
Have you ever been medically advised to change occupation?				Yes		No
Have you ever been medically advised to restrict activity levels?				Yes		No
Are you currently receiving medical treatment?				Yes		No
If Yes, details						
Have you ever had a work injury, disease or made a claim for Workers Compensation?				Yes		No
If Yes, when?		Return to full duty?		Yes		No
Period off work		Period on light duty				
Do you have a current / open Workers Compensation claim?				Yes		No
Do you wear a Medic Alert bracelet?				Yes		No
Are you pregnant?				Yes		No

MEDICATIONS:

Are you currently taking any prescription or over the counter medication? (This includes inhaled, oral, patches, gels, injection or other route of administration)

Medication:	Condition this is for?

Have you been immunised for the following?

Tetanus	Yes		No		Year (if known)	
Hepatitis A	Yes		No		Year (if known)	
Hepatitis B	Yes		No		Year (if known)	
I have previously required Adrenaline for a serious allergic reaction?					Yes	No

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ALLERGIES:

Do you currently have, or have you ever had;

Hay Fever	Yes		No		Contact Dermatitis	Yes		No	
Sinusitis	Yes		No		Eczema	Yes		No	
I am allergic to:					I carry an Epipen (Adrenaline)	Yes		No	

ALCOHOL:

		Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
A	How often do you have a drink containing alcohol?					

		1-2	3-4	5-6	7-9	>10
B	How many standard drinks do you have on a typical day when you are drinking? (*1 Std drink = 285ml beer; 1 glass of wine)*					

		Never	Less than monthly	Monthly	Weekly	Most Days
C	How often do you have six or more standard drinks on one occasion?					
D	How often during the last year have you found that you were not able to stop drinking once you had started?					
E	How often during the last year have you failed to do what was normally expected of you because of drinking?					
F	How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?					
G	How often during the last year have you had a feeling of guilt or remorse after drinking?					
H	How often during the last year have you been unable to remember what happened the night before because you had been drinking?					
		0	1	2	3	4

		No	Yes, but not this year	Yes, during the last year
I	Have you or someone else been injured because of your drinking?			
J	Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?			
		0	2	4

K10 TEST:

		None of the time	A little of the time	Some of the time	Most of the time	All of the time
A	During the last 30 days, about how often did you feel tired out for no good reason?					
B	During the last 30 days, about how often did you feel nervous?					
C	During the last 30 days, about how often did you feel so nervous that nothing could calm you down?					
D	During the last 30 days, about how often did you feel hopeless?					
E	During the last 30 days, about how often did you feel restless or fidgety?					
F	During the last 30 days, about how often did you feel so restless you could not sit still?					
G	During the last 30 days, about how often did you feel depressed?					
H	During the last 30 days, about how often did you feel that everything was an effort?					
I	During the last 30 days, about how often did you feel so sad that nothing could cheer you up?					
J	During the last 30 days, about how often did you feel worthless?					
		1	2	3	4	5

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EPWORTH SLEEPINESS SCALE:

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling tired? This refers to your usual way of life in recent times. Even if you haven't done some of the things recently try to work out how they would have affected you.

		Never	Slight	Mod	High
A	Sitting and reading	☐	☐	☐	☐
B	Watching TV	☐	☐	☐	☐
C	Sitting, inactive in a public place (eg. A theatre or meeting)	☐	☐	☐	☐
D	As a passenger in a car for an hour without a break	☐	☐	☐	☐
E	Lying down to rest in the afternoon	☐	☐	☐	☐
F	Sitting and talking to someone	☐	☐	☐	☐
G	Sitting quietly after lunch without alcohol	☐	☐	☐	☐
H	In a car, while stopped for a few minutes in the traffic	☐	☐	☐	☐
		0	1	2	3

SKIN:

Do you currently have, or have you ever had;

Skin Cancer	Yes ☐	No ☐	Tinea	Yes ☐	No ☐
Dermatitis	Yes ☐	No ☐	Psoriasis	Yes ☐	No ☐

NEUROLOGICAL (HEAD) FUNCTION:

Do you currently have, or have you ever suffered from;

Head injury / concussion	Yes ☐	No ☐	Loss of consciousness	Yes ☐	No ☐
Convulsion or seizure	Yes ☐	No ☐	Dizzy / faint / blackouts	Yes ☐	No ☐
Epilepsy / Fits	Yes ☐	No ☐	Severe migraine	Yes ☐	No ☐
Vertigo or issue effecting balance				Yes ☐	No ☐
Visual disturbance including night or colour blindness				Yes ☐	No ☐

HEARING:

Do you have any hearing loss and/or need for hearing aids				Yes ☐	No ☐
Have you previously made a Workers Compensation claim for hearing loss?				Yes ☐	No ☐

Have you ever had a problem with:

Drugs and/or alcohol	Yes ☐	No ☐	Panic attacks	Yes ☐	No ☐
Depression	Yes ☐	No ☐	Insomnia (unable to sleep)	Yes ☐	No ☐
Anxiety	Yes ☐	No ☐			

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RESPIRATORY (LUNG) FUNCTION:

Do you currently have, or have you ever had;

A cough lasting greater than 3 weeks?	Yes ☐	No ☐
A cough producing phlegm or blood?	Yes ☐	No ☐
Short of breath walking on level ground?	Yes ☐	No ☐
Short of breath walking up a slight hill?	Yes ☐	No ☐
Short of breath waking you in your sleep?	Yes ☐	No ☐
Chest tightness or difficulty breathing?	Yes ☐	No ☐
Wheezy sounding chest when exercising, or around smoke or dust?	Yes ☐	No ☐
Bronchitis, Emphysema, or pneumonia?	Yes ☐	No ☐
Do you, or did you smoke?	Yes ☐	No ☐

If Yes, how many per day? _____ If ex-smoker, when did you cease? _____

Asthma?	Yes ☐	No ☐		
If Yes, diagnosed when?	_____		Usual trigger?	_____
Last episode?	_____			
Under GP / Respiratory Physician care?	Yes ☐	No ☐		
Previous Asthma Workers Compensation claim?	Yes ☐	No ☐		

☐ ☐

Have you ever worked with or been exposed to hazardous substances;

Coal tar pitch volatiles	Yes ☐	No ☐	Asbestos	Yes ☐	No ☐
Hot metal fumes	Yes ☐	No ☐	Polychlorinated biphenyls (PCB)	Yes ☐	No ☐
Crystalline Silica	Yes ☐	No ☐	If yes to above, is this being medically managed	Yes ☐	No ☐

CARDIOVASCULAR (HEART) FUNCTION:

Do you currently have, or have you ever suffered from;

High blood pressure	Yes ☐	No ☐	Chest pain	Yes ☐	No ☐
Heart disease/failure	Yes ☐	No ☐	Blood clot / thrombosis	Yes ☐	No ☐
Stroke	Yes ☐	No ☐	Blood disorder / anaemia	Yes ☐	No ☐
Palpitations	Yes ☐	No ☐	Heat exhaustion / stroke	Yes ☐	No ☐
A cardiac pacemaker or other electrically activated device				Yes ☐	No ☐
Implantation of any clips, stents or valves				Yes ☐	No ☐

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DIABETES

Do you currently have, or have you ever suffered from:

A diagnosis of Diabetes?	Yes ☐	No ☐
Diabetes controlled by diet?	Yes ☐	No ☐
Diabetes controlled by medication?	Yes ☐	No ☐

MUSCULOSKELETAL (MOVEMENT) FUNCTION:

Do you currently have, or have you ever had:

Loss of full lower back function	Yes ☐	No ☐	Painful or swollen joints	Yes ☐	No ☐
Loss of full neck function	Yes ☐	No ☐	Joint sprain / cartilage injury	Yes ☐	No ☐
Loss of full arm / leg function	Yes ☐	No ☐	Fracture / dislocation	Yes ☐	No ☐
Previous overuse syndromes	Yes ☐	No ☐	Provision of orthotics	Yes ☐	No ☐

Muscular strain requiring health professional intervention	Yes ☐	No ☐
Orthopaedic surgery including joint reconstruction, tendon/muscle/ligament repair	Yes ☐	No ☐
Any metallic implants *(eg. plates, screws, pins, rods, joint replacement or other prosthesis)*	Yes ☐	No ☐
Amputation, partial or complete, of any body part	Yes ☐	No ☐
Nerve injury and / or sensory change in any limb	Yes ☐	No ☐
Any electrically activated device implanted for the management of pain	Yes ☐	No ☐

If yes to any of the above, please provide details;

Are you freely able to:

Climb stairs / ladders	Yes ☐	No ☐	Work over uneven ground	Yes ☐	No ☐
Squat / kneel	Yes ☐	No ☐	Work in awkward postures	Yes ☐	No ☐
Work with arms overhead	Yes ☐	No ☐	Work with whole body vibration	Yes ☐	No ☐
Sustain a forward bend	Yes ☐	No ☐	Work with arm hand vibration	Yes ☐	No ☐
Maintain a grip in either hand	Yes ☐	No ☐	Read instruments, signs etc	Yes ☐	No ☐
Lift from floor to above shoulder	Yes ☐	No ☐	Carry in both or either hand	Yes ☐	No ☐

PRE EMPLOYMENT HEALTH ASSESSMENT

DECLARATION:

I declare that the preceding information is true and correct to the best of my knowledge.

I authorise for the company medical officer to obtain any medical information about me from any doctor, clinic or hospital for the purpose of determining my suitability for the job for which I have applied.

I understand that if I give false or misleading information to any of the questions I will, if accepted for employment, be liable to dismissal without notice.

Signature:		**Date:**	
Signature / Witness: *(Parent/Guardian if U18)*		**Date:**	

****End of questionnaire****

PRE EMPLOYMENT HEALTH ASSESSMENT