

PATIENT REGISTRATION FORM FOR PRE-EMPLOYMENT MEDICAL

ACCOUNT BILLING DETAILS:	Company Name:	
	Attention:	
	Address:	
	Phone:	
	Examination Date:	

PERSONAL DETAILS:

(Applicant to complete questions 1-32)

1. Sex: Male Female Date of Birth: ____/____/____ Current Age: _____
2. First Name(s): _____ Surname: _____
3. Address: _____
4. (Number) (Street) (Suburb) (Postcode)
5. Telephone: Home: _____ Work: _____
Mobile: _____
6. Email address: _____
7. Country of Birth: _____
8. Language Spoken: _____
9. Marital Status: Married Single Widowed Divorced De-Facto Separated Unknown
10. Next of Kin (Person to contact in case of an emergency): _____
11. Their contact number(s): _____
12. Medicare Number: _____ Exp Date: ____/____/____

COMPANY / PRE-EMPLOYMENT DETAILS:

- 5 Position you are applying for: _____
- 6 What roles does this job involve: _____
- 7 Company Name: _____
- 8 Company Address: _____
- 9 _____
- 10 Have you done this type of work before? Yes No
- 11 Have you been in contact with irritant chemicals to your skin or lung? Yes No

EMPLOYMENT HISTORY:

PREVIOUS JOBS:

PERIOD OF EMPLOYMENT

- i. _____
- ii. _____
- iii. _____

MEDICAL HISTORY:

(To Be Completed By Applicant)

- 9. What is your weight? _____ kg
- 10. What is your height? _____ cm
- 11. Do you smoke? Yes No If yes, the total number of cigarettes per day? _____
- 12. Do you drink alcohol? Yes No If yes, how many glasses of alcohol per day/week? _____
- 13. Do you use illicit drugs? Yes No If yes, which? _____
- 14. Do you wear glasses? Yes No
- 15. Do you wear contact lenses? Yes No
- 16. Have you ever had a work related injury before? Yes No

If so:	When?	What was the injury?	How long were you off work?
i)	_____	_____	_____
ii)	_____	_____	_____
iii)	_____	_____	_____

- 17. Did you claim compensation for the injuries?..... Yes No
- 18. Do you have any pre-existing/present medical problems?Yes No
If so, please state what they are: i) _____
ii) _____
iii) _____
- 19. Are you taking any medications at present? Yes No
If so, what are they? _____
- 20. Do you have any allergies?..... Yes No
If so, what are they? _____
- 21. Family History/Other (if relevant): _____

- 22. Have you had or do you have now:
 - Dermatitis (or eczema) Yes No
 - Hearing difficulties Yes No
 - Heart trouble or blood pressure Yes No
 - Asthma or any breathing troubles Yes No
 - Diabetes Yes No
 - Epilepsy Yes No
 - Arthritis Yes No
 - Psychiatric problems Yes No
 Details: _____

- 23. What immunisations/vaccinations have you had? And when did you have the immunisations:
 - Hepatitis A Yes No.....When: _____
 - Hepatitis B Yes No.....When: _____
 - Tetanus Yes No.....When: _____

24. When was your last chest x-ray, and where? When: _____ Where: _____

25. Have you ever had a hearing test, and where? When: _____ Where: _____

ONLY TO BE COMPLETED FOR COMMERCIAL VEHICLE EXAMINATIONS (TRUCK DRIVERS) ONLY

(To Be Completed By Applicant)

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- a) What is your driver's license number? _____
- b) How many years experience do you have in the Road Transport Industry? _____
- c) How many kilometers per week (on average) do you travel in your vehicle? _____
- d) Do you generally drive long haul or short haul? _____
- e) Do you generally travel during: daylight hours
 night time hours
 both
- f) Do you perform regular stretching and flexibility exercises? Yes No
- g) Have you been involved in a road accident that has caused physical injury to yourself? Yes No
 If yes, please elaborate: _____

- h) Have you ever had an accident as a result of blacking out or falling asleep at the wheel? Yes No
- i) In the past year, have you ever had to pull off the road because you have become sleepy? Yes No
 If yes, how often has this happened? _____
- j) Have you ever contemplated or attempted suicide?..... Yes No
- k) Have you ever: a) attempted to cut down on your drinking?..... Yes No
 b) been annoyed by other people criticising your drinking? Yes No
 c) felt guilty about your drinking?..... Yes No
 d) taken a morning eye-opener?..... Yes No
- l) Do you use any drugs or medications not prescribed for you by a doctor? Yes No

MEDICAL EXAMINATION

*(Doctor to complete
questions 1-10)*

Patient sticker

1) **WEIGHT?** _____ kg

• **HEIGHT?** _____ cm

2) **URINE ANALYSIS:**

- pH - Positive Negative _____
- Protein - Positive Negative _____
- Glucose - Positive Negative _____
- Blood - Positive Negative _____
- Ketones - Positive Negative _____
- Other - Positive Negative _____

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3) **GENERAL APPEARANCE:**

(include signs of alcohol or other drug abuse)

4) **VISION:**

Visual Acuity:

Uncorrected:- Right: 6 / ____ ____ Left: 6 / ____ ____
Corrected:- Right: 6 / ____ ____ Left: 6 / ____ ____

Colour Vision: _____ Incorrect ishihara plates

Vision Fields: _____

5) **HEARING:**

Normal Abnormal

6) **SKIN:**

7) **CARDIOVASCULAR:**

BP: _____

Pulse: _____

Apex Beat: _____

Oedema: _____

8) **MUSCULOSKELETAL:**

• Gait: _____

• Spine: - Cervical: _____

- Thoracic: _____

- Lumber: _____

9) **RESPIRATORY:**

Extra Sounds:

10) **GIT:**

Date: ____/____/____

Completed By: _____

Signature: _____