

MEDICAL QUESTIONNAIRE

ACN 065 481 049

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OFFICE USE ONLY

EXECUTIVE MANAGER Initial & Date :

INFECTION CONTROL Initial & Date:

The purpose of this Questionnaire is to assist in matching a prospective employee to the suitability of a job and the tasks required. In accordance with Peel Health Campus privacy policy you are entitled to change or have access to your personal and sensitive information. The information contained herein may be released to a third party (medical practitioner) for the purpose of evaluating your fitness to perform the duties.

SECTION A: APPLICANTS PARTICULARS

Surname:		First name:		Today's date:	
Address:		Mobile:		Home:	
Post Code:					
Date of Birth		<input type="checkbox"/> female <input type="checkbox"/> male	Position applying for		Department

SECTION B: MEDICAL HISTORY

Do you have, or have you ever suffered from:	YES	NO
Asthma, Bronchitis, Wheeze or other lung disorders?		
Allergies, Hay Fever, Sinus problems, or Latex allergies?		
Skin Rashes, Eczema, Dermatitis or Psoriasis?		
Heart Disease, Blood pressure disorders or Varicose Veins?		
Hernia or abdominal problems?		
Major Head Injuries, Epilepsy or Severe Migraines?		
Anxiety, Depression or other Psychiatric conditions?		
Diabetes?		
Any eye or ear (including hearing) problems?		
Any other medical or surgical problems not mentioned above?		
Are you currently being treated by any doctor for any illness?		
Are you taking medications, drugs or injections for medical reasons on a regular basis?		
Have you sustained any injuries to: <input type="checkbox"/> Back <input type="checkbox"/> Shoulder <input type="checkbox"/> Neck <input type="checkbox"/> Joints <input type="checkbox"/> Fractures <input type="checkbox"/> Strains <input type="checkbox"/> Arthritis Gout <input type="checkbox"/> RSI <input type="checkbox"/> Carpel Tunnel <input type="checkbox"/> Other Disorders:		

If you have answered YES to any of the previous questions, please give detail

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SECTION B: MEDICAL HISTORY continued

Do you have any conditions which need to be considered by your potential employer that may prevent or limit you performing the work for which you have applied?
 Yes No
 Please provide details _____

Do you, or have you suffered from back pain or had any back problems including injuries, strains, fractures, or other disorders?
 Yes No
If you have answered YES, please answer the following questions
 What was the location and type of pain? _____
 How long did you have the pain? _____
 How long since you have experienced symptoms? _____

SECTION C: WORKERS' COMPENSATION

Have you ever made a claim for compensation following a work place injury, motor vehicle accident or any other accident/incident?
 Yes No

If you have answered YES, please answer the following questions
 When did the accident occur?
 What injury did you sustain?
 How much time off work did you require?
 Did you successfully complete a rehabilitation program? Yes No
 Has the claim been settled? Yes - date: No

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, wilfully or falsely represented himself as not having previously suffered from the disability, the subject of the claim for compensation.

SECTION D: DECLARATION

I certify the above statements are true and I authorise my private doctor to supply any additional information that may be required in connection with any sickness or accidents for which he/she has treated me. I acknowledge that at the discretion of Peel Health Campus I may be required to undergo medical assessment by a Peel Health Campus nominated doctor.

I am aware that if any statements above are purposely misleading I will be liable to instant dismissal from employment.

Signature of Applicant: _____ Date: _____

Signature of Witness: _____ Date: _____

Name of Witness: _____

SECTION E-INFECTIOUS DISEASES

Immunisation Requirements

Have you had the following Vaccinations?

Please answer by ticking the appropriate box.

Attach copies of previous tests and vaccination records to this form.

MRSA

NO YES

Have you worked or been a patient in a hospital outside of Western Australia in the past 12 months?

If yes - you will be required to obtain a request form for MRSA clearance and proceed to the laboratory for swab collection prior to beginning employment

Hepatitis B

NO YES

Have you had a complete course of Hepatitis B vaccine (3 dose course)?

Have you had a blood test to confirm your immunity?

If yes- please supply evidence

Vaccination and/or laboratory evidence of immunity is strongly recommended if you are at occupational risk. (i.e. in contact with blood or body fluids). If you have never been immunized or have not completed a primary course you will be contacted by a member of the infection control team and offered immunization.

Tuberculosis

1. Country of birth? _____

2. Countries you have lived or worked in for more than six months, other than country of birth?

3. Are you Aboriginal or Torres Strait Islander? _____

Have you ever received a BCG (ie vaccination against Tuberculosis)?

NO YES

If yes -please supply evidence

Have you had a Mantoux test (TB Skin Test)?

If yes Date obtained.....

Was result: Positive Negative

NB: A copy of this result is required

If you are not able to provide documented evidence of your Mantoux (TB Skin Test) you will need to have a repeat Mantoux. This can be conducted on Campus. To make an appointment, please contact Infection Control on (08) 9531 8513.

Varicella

NO YES

Have you ever had chicken pox or shingles?

Have you had the Varicella (chickenpox) vaccine?

Have you had a blood test to confirm your immunity?

If yes- please supply evidence

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Measles, Mumps, Rubella (MMR) Vaccine	NO	YES
Have you had the Measles, Mumps, Rubella vaccine (MMR)?	<input type="checkbox"/>	<input type="checkbox"/>
One dose of MMR	<input type="checkbox"/>	<input type="checkbox"/>
Two doses of MMR	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a blood test to confirm your immunity?	<input type="checkbox"/>	<input type="checkbox"/> <i>If yes- please supply evidence</i>

Those born after 1966 must provide evidence of either receiving 2 doses of MMR vaccine or laboratory evidence of immunity. Staff who have received only a single dose of MMR will be offered a second dose to complete their course. Persons born before 1966 are considered immune to measles, but may have measles, mumps and rubella (MMR) vaccination if requested.

Diphtheria-Tetanus, Whooping Cough	NO	YES
Have you had an adult Pertussis (Whooping Cough/dTPa) vaccine?	<input type="checkbox"/>	<input type="checkbox"/> <i>If yes- please supply evidence</i>

An adult dose of Pertussis vaccine is recommended for all staff that have direct contact with patients.

Influenza	NO	YES
Have you had an influenza vaccination this year?	<input type="checkbox"/>	<input type="checkbox"/> <i>If yes- please supply evidence</i>



Please provide original immunization records and/or copies of laboratory blood tests at your interview so they may be copied and attached to this form. If you can not provide evidence please seek advice from the Infection Control Team.

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ACTION						
INVESTIGATION	EVIDENCE SUPPLIED			LAB TEST	RESULT	COMMENT
Measles	Yes	No	N/A	Yes No N/A		
Rubella	Yes	No	N/A	Yes No N/A		
Varicella	Yes	No	N/A	Yes No N/A		
Hep B	Yes	No	N/A	Yes No N/A		
MRSA screen	Yes	No	N/A	Yes No N/A		
Mantoux	Yes	No	N/A	Yes No N/A		
VACCINATION		DATE			COMMENT	
MMR	Yes	No	N/A			
Varicella	Yes	No	N/A			
Pertussis	Yes	No	N/A			
HepB	Yes	No	N/A			

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