Community Care TASMANIA

Pre - Employment Medical Questionnaire

Name: …… **D.O.B** ……

Address: ……..……

Contact No: ……..

Our organisation has a duty of care to provide and maintain a safe working environment so far as reasonably practical and to ensure employees are not exposed to hazards. Your completion of this form allows us to obtain relevant information so we can ensure, as much as possible, that you are a suitable physical and medical match to the role for which you are applying and can carry out the role without the risk of harm to yourself or others.

All details provided on this form are treated as strictly confidential in accordance with The Privacy Act and all components relating to Personal Information.

PAST AND PRESENT MEDICAL INFORMATION *Please circle appropriate response*

** How would you describe your general health most of the time?

Excellent Very good Usually good Just OK Sometimes not so good

** Have you had any significant illness, admission to hospital or surgical procedure performed in the last five (5) years? (Excluding normal pregnancy and delivery) No Yes

Please specify: _____

** Are you currently being treated by a doctor for any physical or psychological condition?

No Yes

Please specify: _____

** Are you currently taking any prescribed medication? No Yes

Please specify: _____

** Do you have any known allergies? No Yes

Please specify: _____

** Have you ever sustained an injury in a vehicle accident or sporting incident that you required medical attention? No Yes

Please specify: _____

Have you or do you suffer from any of the following?

1. Have you tested positive for COVID-19 in the last 6 months?

   Yes No *If yes, please provide details:*

2. Have you had a flu shot this cold and flu season?

   Yes No *If yes, please provide details:*

3. Bone or joint problems? e*g: Fractures, breaks*

   Yes No *If yes, please provide details:*

4. Muscle, tendon or ligament problems?

   Yes No *If yes, please provide details:*

5. Pains, aches, numbness or weakness in the neck, shoulders, arms, hands or fingers?

   Yes No *If yes, please provide details:*

6. Feet, ankles, knee, hip problems?

   Yes No *If yes, please provide details:*

7. Back complaint or back injury?

   Yes No *If yes, please provide details:*

8. Any other illness, injury, health condition or operation not mentioned?

   Yes No *If yes, please provide details:*

** Do you have any condition or problem that may impact upon your ability to perform your job?

Yes No *If yes, please provide details:*

** Do you have any fears or phobias that may impact your ability to do your job? *Eg: Animals, birds*

Yes No *If yes, please provide details:*

Declaration
I hereby declare that: I have read and understood the conditions of this form. I understand that the information that I provide will be retained on my personnel file and that my employer reserves the right to access and use the information over the duration of my employment for any reasonable purposes or if so required by law.
My answers relating to my medical history are true and complete to the best of my knowledge.

Signed: _____ Date: ___/____/_____