

TASWORKHEALTH

OCCUPATIONAL HEALTH REHABILITATION AND INJURY MANAGEMENT SERVICES

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HEALTH ASSESSMENT QUESTIONNAIRE

The information given by you in this questionnaire is confidential. It is designed to help with the assessment of your health to ensure that you can carry out your duties without risk to yourself and others.

Surname		Given Names	Date	Date of Birth	
Home Address			Telepho		
•••	Name, Address, Teleph				
•••	Usual Medical Practitio	ner Address		• • • • • • • • • • • • • • • • • • • •	
1.	Are you presently in good hea	ulth?		Y/N	
2.	,	aking (including non prescription dr	•		
3.	Do you use recreational drugs	s apart from alcohol and tobacco?		Y/N	
4.	Have you had a tetanus inject	ion in the past 10 years?		Y/N	
5.	•	in an accident of any type? If yes give		Y/N	
6.	How much tobacco do you sr	noke each day? (If ex smoker when o	did you cea	se).	

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7.	How much alcohol do you consume daily? Has your consumption varied in the last two years?	Y/N
	rias your consumption varied in the last two years:	1/11
8.	Have you ever had any of the following?	
	a. stomach, bowel or liver trouble	Y/N
	b. frequent headaches	Y/N
	c. fainting spells, dizziness, fits, blackouts, seizures, epilepsy of any kind	Y/N
	d. is there a defect in your vision.	Y/N
	e. have you ever had any joint, muscle (including tendonitis), back, or neck	
	complaints	Y/N
	f. have you any trouble with your heart (including angina) or raised blood	
	pressure	Y/N
	g. are you troubled by shortnesss of breath or any lung complaint	
	including asthma	Y/N
	h. have you kidney/bladder or urinary troubles.	Y/N
	i. are you diabetic or ever had sugar found in your urine	Y/N
	j. are there any diseases that run in your family	Y/N
	k. are you allergic to medications or any substances	Y/N
	l. do you suffer from any skin complaints.	Y/N
	m. do you suffer from cancer or tumour of any kind	Y/N
	n. do you suffer from ear discharge or sinus trouble	Y/N
	o. have you ever suffered from nervous, mental or psychiatric illness	Y/N
C	omments:	
C	Julinents.	
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<u>Occu</u>	pational	<u>History</u>

Please list former occupations.

	_				
Dates		Name of Employer	Nature of Work		
From	То				
1.					
2.					
3.			·		
4.					
5.			·		
6.					
1. Have you ever suffered any disease or condition caused by your work? Yes/No					
authorize the Comp	pany Do	octor (Dr. J. O'Sullivan) to ma	aire are to the best of my knowledge. In the latest ake available details of my health ompany personnel on request.		
Applicants signature					
Witness					
Place & Date					