THE BRISBANE AVMED CENTRE

To be completed by applicant prior to examination

Surname:	**First:**
Date of birth:	Tel:

Applicant consent:

I _____ hereby consent to undertaking a health questionnaire and medical examination for the purposes of pre-employment or other occupational reasons with The AvMed Centre (the nominated provider). I further declare that the information I provide will be a true and correct account of my past and present medical history and personal habits. I authorise the examining professional to pass on the results of this assessment to the contracting entity (likely to be a current or prospective employer) and to make recommendations regarding my suitability for employment and/or my possible medical risks. I understand this is a personal opinion and the contracting entity may or may not act upon this and this in no way opens The AvMed Centre to any liability for decision made by contacting entities. Further I understand that The AvMed Centre is not in any way acting as a treating doctor and owes no duty of care to me. Should a significant health problem by detected it is my responsibility to seek appropriate medical care from my usual treating doctor (The AvMed centre will communicate any relevant medical information to assist in this).

Signed by Applicant:_____ Date_____

Personal Habits/Information:

Do you smoke?	**Y**	**N**	**Number of cigarettes per day**
Do you drink alcohol?	**Y**	**N**	**Number of standard drinks per week**
Have you ever sought treatment for drug or alcohol problems?	**Y**	**N**	
Have you any allergies?	**Y**	**N**	**What to?**
Do you take any prescription medication(s)?	**Y**	**N**	**Which ones?**
Have you a family history of serious illness?	**Y**	**N**	**What and in whom?**
Have you been off work sick for a continuous period longer than 2 weeks ?	**Y**	**N**	**When and why?**
Have you visited a chiropractor of physiotherapist in the last 2 years?	**Y**	**N**	**Why?**
Do you have a communicable disease (eg HIV,Hepatitis,TB)?	**Y**	**N**	**Which?**
Have you been advised against any employment because it may put you at risk?	**Y**	**N**	**Outline**

MEDICAL HISTORY

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING?	Y	N	DETAILS……
Blackouts, Fits ,Epilepsy or Dizziness?			
Hypertension			
Persistent headaches or migraine.			
Head injury with loss of consciousness or skull fracture			
Heart Disease including rhythm disorders			
Stomach or duodenal ulcer			
Any other bowel disorder			
Kidney stones			
Other kidney or bladder disease			
Cancer other than skin			
Skin cancer			
Prostate disease			
Diabetes			
Osteoarthritis of any joints			
Spinal disc disease or chronic back pain, sciatica or stiffness			
Any visual problems			
Any hearing disorder or other ear problems eg tinnitus			
Skin disease including eczema or contact dermatitis			
Herniae			
Surgical operations			
Snoring, Obstructive sleep apnoea or excessive sleepiness **(Fill in attached Epworth Sleepiness Scale (ESS) questionnaire if answering yes).**			
Asthma or Chronic airways disease			
High cholesterol			

Blood Disorders including clots (DVT or PE)			
Blocked arteries			
Any psychiatric illness (eg depression, bipolar, schizophrenia, anxiety, stress			
Pregnancy or pregnancy related problems			
Hay fever or other environmental allergic disorders			
Stroke			
Unexplained pain or disabling symptoms			

MORE SPACE FOR DETAILS;

_____
_____
_____
_____
_____
_____

NAME_____ **DATE**_____

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations?

Choose the most appropriate number for each situation:

0= would never fall asleep

1= slight chance of falling asleep

2= moderate chance of falling asleep

3= high chance of falling asleep

Activity	*Please circle the most appropriate response*			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting in the cinema or theatre	0	1	2	3
As a passenger in a car on 1hr journey	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch	0	1	2	3
In a car in traffic for a few minutes	0	1	2	3

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Name_____ Date_____