# AlfredHealth

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☐ Alfred ☐ Sandringham ☐ Caulfield

## HYPERBARIC HEALTH QUESTIONNAIRE

| Last name* | | First name/s* | |
|---|---|---|---|
| Date of birth* | | Sex ☐ Female ☐ Male ☐ Other | |

*mandatory fields

Steps to completing this questionnaire,

1. Save questionnaire to your computer and answer questions
2. **email to** tunnelling.hyperbaric@alfred.org.au
3. **or** post to: Hyperbaric Service, Alfred Health, PO Box 315, PRAHRAN VIC 3181

- If you have questions – call **9076 2269** between 8:00am & 4:30pm Monday to Friday

This questionnaire is the first part of your compressed air work occupational medical fitness assessment. Your responses will be saved to your Alfred Health patient record and may be shared with your employer if we are requested to do so. These questions are designed to assist the examining Doctor to determine if you are medically fit and able to safely perform the tasks for the proposed position.

| **Health questionnaire** | If yes, provide details |
|---|---|
| Are you being treated by any doctor for any illness or injury? | ☐ Yes |
| Are you taking any regular medication? Including all tablets, puffers, eye drops, vitamins / herbal medicine etc | ☐ Yes |
| Have you ever had any operation or been hospitalised? | ☐ Yes |
| Have you been immunised against Hepatitis B? | ☐ Yes |
| Date of last Tetanus immunisation | ☐ Yes Date: |
| Have you ever injured yourself at work or suffered an industrial disease? | ☐ Yes |
| Have you ever been on Workers Compensation? | ☐ Yes |
| Have you ever lodged a Hearing Loss Claim? | ☐ Yes |
| Do you have any medical condition or disability that could affect your employment in the proposed occupation? | ☐ Yes |
| Are you or could you be pregnant? | ☐ Yes |
| Have you ever had an X-ray or CT scan of the chest? | ☐ Yes ☐ No |
| If yes, - was this for the assessment of dust diseases or silicosis? | ☐ Yes ☐ No ☐ Not applicable ☐ Don’t know |
| - what year was this scan conducted? | |
| - where did you get this scan? | |
| Is this your first compressed air work fitness assessment? | ☐ Yes ☐ No |
| If no,- when was your last compressed air work fitness assessment? | |
| - which compressed air work project/s have you worked on previously? | |
| Trade qualifications | |
| Job description of current role | |

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| Last name* | | First name/s* | |
|---|---|---|---|

## Have you suffered from (*now or previously*) from any of the following

| | | | |
|---|---|---|---|
| Respiratory problems / asthma / bronchitis | ☐ Yes | Diabetes ☐ Type 1 ☐ Type 2 ☐ Unsure | ☐ Yes |
| Blood pressure ☐ High ☐ Low | ☐ Yes | Heart attack / angina / cardiac disease | ☐ Yes |
| Cancer | ☐ Yes | Stomach ulcers or pain | ☐ Yes |
| Epilepsy or seizures | ☐ Yes | Migraine headaches / blackouts / fainting | ☐ Yes |
| Hernia | ☐ Yes | Bowel / bladder problems / incontinence | ☐ Yes |
| Back pain or slipped disc | ☐ Yes | Earache or discharging from ears | ☐ Yes |
| Skin conditions / dermatitis or eczema / existing wounds | ☐ Yes | Mental health problems / depression / anxiety | ☐ Yes |
| HIV or Aids | ☐ Yes | Hepatitis | ☐ Yes |
| Emphysema or pneumonia | ☐ Yes | Arthritis or joint problems | ☐ Yes |
| Claustrophobia | ☐ Yes | Passing or vomiting blood | ☐ Yes |
| Allergy to: ☐ chemicals ☐ medication ☐ other, list | | | |

## Do you have, or have you ever had, trouble with your *Tick all that apply*

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Back | ☐ Yes | Neck | ☐ Yes | Ankles | ☐ Yes | Hips | ☐ Yes |
| Feet | ☐ Yes | Shoulder | ☐ Yes | Knees | ☐ Yes | Elbows | ☐ Yes |
| Eyes or Ears | ☐ Yes | Wrists | ☐ Yes | | | | |

## Lifestyle

| | | *Provide details* | |
|---|---|---|---|
| Have you ever smoked or vaped? | ☐ Yes | Number per day? | |
| | | Date ceased? | |
| Do you drink alcohol | ☐ Yes | Drinks per week? | |
| Do you use recreational drugs? | ☐ Yes | Amount? | |
| | | Type? | |

## STATEMENT OF AUTHORISATION & CONSENT TO COLLECT INFORMATION

* I hereby certify that the information provided is correct to the best of my knowledge.

* I authorise the examining Doctor or a representative of the nominated Medical Service to release any information acquired from this History and the Medical Examination Report to the appropriate representative of my Employer.

* I authorise the appropriate representative of Alfred Health to request and review medical information including imaging from external providers for the purposes of completing my occupational medical assessment.

| **Signature** | | **Date** | |
|---|---|---|---|

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