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## Goldfields Occupational Medicine – Pre Employment Medical Assessment

| Personal Details                 |  |         |  |         |  |
|----------------------------------|--|---------|--|---------|--|
| Name:                            |  | DOB:    |  | Gender: |  |
| Address:                         |  |         |  |         |  |
| Phone (Home):                    |  | Mobile: |  |         |  |
| Employer:                        |  |         |  |         |  |
| Proposed Position:               |  |         |  |         |  |
| WA Mines Health Surveillance No: |  |         |  |         |  |
| Photo ID Type                    |  | ID No:  |  |         |  |
| Signature:                       |  |         |  |         |  |
| Assessor Signature:              |  |         |  |         |  |

| Previous Employment Types                                                                                                       |                          |                          |                          |                         | (Mark with a  )          |                       |                          |
|---------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|-------------------------|--------------------------|-----------------------|--------------------------|
| Identify previous experiences to the following employment types or environmental exposures associated with past employment.     |                          |                          |                          |                         |                          |                       |                          |
| <i>Have you ever worked as a:</i>                                                                                               |                          |                          |                          |                         |                          |                       |                          |
| Bar Person:                                                                                                                     | <input type="checkbox"/> | Stable Hand:             | <input type="checkbox"/> | Surface Miner:          | <input type="checkbox"/> | Farmer:               | <input type="checkbox"/> |
| Underground Mining:                                                                                                             | <input type="checkbox"/> | Oxy Welder:              | <input type="checkbox"/> | Arc Welder:             | <input type="checkbox"/> | Beer Brewer:          | <input type="checkbox"/> |
| Spray Painter:                                                                                                                  | <input type="checkbox"/> | Fingernail Tech:         | <input type="checkbox"/> | Sewage / Waste:         | <input type="checkbox"/> | Smelter Crew:         | <input type="checkbox"/> |
| Mechanic:                                                                                                                       | <input type="checkbox"/> | Noisy Workplace:         | <input type="checkbox"/> | Sandblaster:            | <input type="checkbox"/> | Insulation Installer: | <input type="checkbox"/> |
| Bird Keeper:                                                                                                                    | <input type="checkbox"/> | Chicken / Fowl Farming   | <input type="checkbox"/> | Driller / Offsider      | <input type="checkbox"/> | Impact Driller:       | <input type="checkbox"/> |
| Aviation Industry:                                                                                                              | <input type="checkbox"/> | Diesel Mech / Fitter:    | <input type="checkbox"/> | Boilermaker:            | <input type="checkbox"/> | Fitter:               | <input type="checkbox"/> |
| Asbestos Disposal:                                                                                                              | <input type="checkbox"/> | Aircraft Bag Handler:    | <input type="checkbox"/> | Jack Hammer Operator:   | <input type="checkbox"/> | Tyre Fitter:          | <input type="checkbox"/> |
| <i>Have you ever participated in the social activities of:</i>                                                                  |                          |                          |                          |                         |                          |                       |                          |
| Shooting (Firearms):                                                                                                            | <input type="checkbox"/> | Drag Racing:             | <input type="checkbox"/> | Regular Night Clubbing: | <input type="checkbox"/> |                       | <input type="checkbox"/> |
| Rodeo Activities:                                                                                                               | <input type="checkbox"/> | Driving Heavy Equipment: | <input type="checkbox"/> | Pyrotechnics:           | <input type="checkbox"/> |                       | <input type="checkbox"/> |
| <i>List your social activities, including sports. (i.e. Night Clubbing, Biking Riding, Swimming, Camping, Photography etc.)</i> |                          |                          |                          |                         |                          |                       |                          |
|                                                                                                                                 |                          |                          |                          |                         |                          |                       |                          |
|                                                                                                                                 |                          |                          |                          |                         |                          |                       |                          |
|                                                                                                                                 |                          |                          |                          |                         |                          |                       |                          |



## Goldfields Occupational Medicine – Pre Employment Medical Assessment

| Have you ever had or suffered from any of the following: (Attach description page where needed) |  |                                         |  |                           | (Mark with a <span style="color: green;">✔</span> ) |
|-------------------------------------------------------------------------------------------------|--|-----------------------------------------|--|---------------------------|-----------------------------------------------------|
| Diabetes                                                                                        |  | Fitting / Seizure                       |  | Sudden Fainting           | Heat Stroke                                         |
| Black Outs                                                                                      |  | Back Injury                             |  | Knee Weakness             | Ankle Weakness                                      |
| Elbow Strain                                                                                    |  | Wrist Strain                            |  | Repeated Sprain Ankle     | Fractures of arms / legs                            |
| Aching Feet                                                                                     |  | Partial / Full Amputations              |  | Knee Cartilage Removal    | Repetitive Strain Injury                            |
| Neck injury or pain                                                                             |  | Cracking / Popping Joints               |  | Anti-Inflammatory Drugs   | Operation on your back                              |
| Tennis Elbow                                                                                    |  | Golfers Elbow                           |  | Knee give way on you      | Knee lock up on you                                 |
| Do you wear orthotics                                                                           |  | Dental Problems                         |  | Asthma, COPD, TB          | Sleep Apnoea                                        |
| Persistent cough                                                                                |  | Persistent Throat clearing              |  | Common cold               | Pneumonia                                           |
| Wheeze Chest                                                                                    |  | Short of breath walking on level ground |  | Morning cough             | High Blood Pressure                                 |
| High Cholesterol                                                                                |  | Heart pain                              |  | Irregular heart beat      | Heart Murmur                                        |
| Bleeding Disorder                                                                               |  | Prolapse of any type                    |  | Any Operations            | Eye Injury                                          |
| Short / Long sighted                                                                            |  | Vision Disturbance                      |  | Night Blindness           | Persistent urine infections                         |
| Kidney / Gall stones                                                                            |  | Kidney Disorder                         |  | Kidney / Bladder Disease  | Hernias of any type                                 |
| Gastric Ulcer                                                                                   |  | Gastric reflux / Heartburn              |  | Vomit or Urinated Blood   | Appetite Changes                                    |
| Addiction to Alcohol                                                                            |  | Unresolved Addiction to Alcohol         |  | Liver Problems            | Hepatitis                                           |
| Fall Asleep Driving                                                                             |  | Offence for Drunk Driving               |  | Persistent sleep problems | Vehicle accident leading to hospitalisation         |
| Persistent Headaches                                                                            |  | Mood Swings                             |  | Unresolved Depression     | Unresolved Psychosis                                |
| Allergic reaction                                                                               |  | Ruptured Ear Drum(s)                    |  | Persistent Ear Infections | Ringing in ears (Tinnitus)                          |
| Cancer                                                                                          |  | Fear of heights                         |  | Fear of confined spaces   | Fear of flying                                      |

| Additional Questions |                                                               |      |  |         |  |                           |  |             |  | ✔     | ✘ |  |
|----------------------|---------------------------------------------------------------|------|--|---------|--|---------------------------|--|-------------|--|-------|---|--|
| 1.                   | Do you smoke?                                                 |      |  |         |  |                           |  |             |  |       |   |  |
|                      | If Yes, what type?                                            | Pipe |  | Tobacco |  | Cigar                     |  | Tailor-made |  | Other |   |  |
| 2.                   | Do you consume Alcohol?                                       |      |  |         |  |                           |  |             |  |       |   |  |
|                      | If Yes, preferred drink type?                                 |      |  |         |  | Standard drinks per week? |  |             |  |       |   |  |
| 3.                   | Do you engage in regular activity or exercise?                |      |  |         |  |                           |  |             |  |       |   |  |
|                      | If Yes, please provide example:                               |      |  |         |  |                           |  |             |  |       |   |  |
|                      | If Yes, how many times per week?                              |      |  |         |  |                           |  |             |  |       |   |  |
| 4.                   | Have you consulted with your Doctor in the past three months? |      |  |         |  |                           |  |             |  |       |   |  |



| <i>Additional Questions (continued)</i> |                                                                                                | ✓ | ✗ |
|-----------------------------------------|------------------------------------------------------------------------------------------------|---|---|
| 5.                                      | Have you consulted with your Doctor in the past three months?                                  |   |   |
| 6.                                      | Have you consulted with a Dentist in the past three months?                                    |   |   |
| 7.                                      | Have you, or are you seeing a Physiotherapist or Chiropractor (In the last 12 months)?         |   |   |
| 8.                                      | Is there any reason why you would not be able to wear safety equipment (i.e. gloves, goggles)? |   |   |
| 9.                                      | Have you ever fallen a distance of twice your body height?                                     |   |   |
| 10.                                     | Is there a familial medical condition in your immediate family?                                |   |   |
| Description:                            |                                                                                                |   |   |

### Chest X-Ray Designated Work Categories

Have you worked in any of the following positions or combinations thereof, for at least the past 5 years?

#### **Underground Mining**

| <b>Employment Type</b>                 | <b>Response</b> |
|----------------------------------------|-----------------|
| <i>Foreman / Shift Boss</i>            |                 |
| <i>Production / Development</i>        |                 |
| <i>Longhole Drill and Blast</i>        |                 |
| <i>Diamond Drillers / Raise Borers</i> |                 |
| <i>Loading / Transport</i>             |                 |
| <i>Ground / Roof Support</i>           |                 |
| <i>Service Occupations</i>             |                 |

#### **Surface Mining Work Categories**

| <b>Employment Type</b>                           | <b>Risk Product</b>              | <b>Response</b> |
|--------------------------------------------------|----------------------------------|-----------------|
| <i>Blast hole drilling</i>                       | <i>Gold, Nickel, Silicon</i>     |                 |
| <i>Charging and blasting</i>                     | <i>Gold, Nickel, Silicon</i>     |                 |
| <i>Exploration Activities – Drill / Sampling</i> | <i>All types, all activities</i> |                 |
| <i>Open-Cut Service Occupations</i>              | <i>Gold, Nickel, Silicon</i>     |                 |
| <i>Sample Preparation</i>                        | <i>Gold, Nickel, Silicon</i>     |                 |
| <i>Sampler</i>                                   | <i>Gold, Nickel, Silicon</i>     |                 |
| <i>Sampler Plant Operator</i>                    | <i>Gold, Nickel, Silicon</i>     |                 |
| <i>Crushing / Screening Operator</i>             | <i>Gold, Nickel, Silicon</i>     |                 |



| <b>Non-Mining Work Categories</b>                                                     |                     |                 |
|---------------------------------------------------------------------------------------|---------------------|-----------------|
| <b>Employment Type</b>                                                                | <b>Risk Product</b> | <b>Response</b> |
| Sandblasting                                                                          |                     |                 |
| Tunnelling / Road Construction                                                        |                     |                 |
| Foundry Work                                                                          |                     |                 |
| Any occupations involving potential exposure or clinical assessment indicates a need. |                     |                 |

**A Chest X-Ray is determined by the medical examiner and based on history and clinical examination.**

| <b>Workers Compensation</b>                            |  | ✓ | ✗ |
|--------------------------------------------------------|--|---|---|
| Have you ever had a Workers Compensation Injury claim? |  |   |   |
| If Yes, When (Year):                                   |  |   |   |
| Reason:                                                |  |   |   |
| Employer Name:                                         |  |   |   |
| Is this claim closed?                                  |  |   |   |

**Declaration and Release**

I do solemnly declare that each and every answer made in regard to my medical history as listed herein is true and correct to the best of my knowledge and I have not deliberately withheld any information in regard to my personal health that may affect my medical assessment. I have maintained 16 hours of quiet time prior to having my audiometric (hearing) test performed. I hereby authorise the examining health care professionals to release the "MINE, QUARRY WORKER'S AND GENERAL MEDICAL HEALTH ASSESSMENT REPORT" as an open document (available to potential employer or appropriate other as required in evidence that a comprehensive medical has been completed). I authorise a copy of my medical, audiogram and other investigations to be released to my employer and held as a confidential document to which the appropriate privacy act of my state applies.

Explanation: The completed medical is a confidential document and may not be released to a third party. As a result the "Mine, Quarry Worker's and General Medical Health Assessment Report" was produced so that a third party may have evidence that the candidate has completed a full and comprehensive pre-employment medical without divulging the personal and confidential content of the medical.

|                             |  |       |  |
|-----------------------------|--|-------|--|
| My designated employers is: |  |       |  |
| Candidate Name:             |  | Date: |  |
| Signature:                  |  |       |  |
| Witness Name:               |  | Date: |  |
| Signature:                  |  |       |  |