

PLEASE READ AND COMPLETE ALL QUESTIONS:

Please complete all questions in the following medical questionnaire. For any question that you answer "YES" please provide details.

Section 79 of the Western Australian Workers Compensation and Injury management Act 1981 requires you to disclose any prior illness or injury otherwise you may not be entitled to compensation in the event of illness or injury.

"Wilful and false representation"

Where it is proved that the worker has, at the time of seeking or entering employment in respect of which he claims compensation for an injury, wilfully and falsely represented himself as not having previously suffered from the injury an arbitrator may in the arbitrators discretion refuse to award compensation with otherwise would be payable"

[Section 79 amended by No. 48 of 1993 s. 28(1); No. 42 of 2004s. 63, 146 and 147.]

MEDICAL HISTORY – HAVE YOU EVER EXPERIENCED OR SEEN A DOCTOR OR THERAPIST FOR ANY OF THE FOLLOWING CONDITIONS:

| Question | Yes | No | Details |
|---|--------------------------|--------------------------|---------|
| Lung Problems /Bronchitis | <input type="checkbox"/> | <input type="checkbox"/> | |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | |
| Blood Pressure / Heart Problems / Circulatory Disorders | <input type="checkbox"/> | <input type="checkbox"/> | |
| Anxiety / Depression | <input type="checkbox"/> | <input type="checkbox"/> | |
| Fits / Seizures / Blackouts | <input type="checkbox"/> | <input type="checkbox"/> | |
| Stomach Problems / Ulcers | <input type="checkbox"/> | <input type="checkbox"/> | |
| Repetitive Strain / Over Use conditions | <input type="checkbox"/> | <input type="checkbox"/> | |
| Arthritis / Rheumatism | <input type="checkbox"/> | <input type="checkbox"/> | |
| Joints – Pain or Fractures | <input type="checkbox"/> | <input type="checkbox"/> | |
| Back or Neck Pain / Discomfort / Stiffness | <input type="checkbox"/> | <input type="checkbox"/> | |
| Loss of Hearing | <input type="checkbox"/> | <input type="checkbox"/> | |
| Visual (Eyesight) Impairments | <input type="checkbox"/> | <input type="checkbox"/> | |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | |
| Skin Disorders / Dermatitis | <input type="checkbox"/> | <input type="checkbox"/> | |
| Have you ever had any surgery | <input type="checkbox"/> | <input type="checkbox"/> | |

LIFESTYLE HISTORY

| Question | Yes | No | Details |
|---|--------------------------|--------------------------|---------|
| Do you smoke or have you ever been a smoker? | <input type="checkbox"/> | <input type="checkbox"/> | |
| If you smoke, how many cigarettes do you smoke / day? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Do you undertake any regular exercise? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Do you drink alcohol? | <input type="checkbox"/> | <input type="checkbox"/> | |
| If you drink alcohol, how many standard drinks per day? | <input type="checkbox"/> | <input type="checkbox"/> | |

Perth Professionals

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| PHYSICAL ABILITIES – DO YOU HAVE, OR HAVE YOU EVER HAD DIFFICULTY WITH ANY OF THE FOLLOWING: | | | |
|--|--------------------------|--------------------------|---------|
| Question | Yes | No | Details |
| Hot / Cold conditions | <input type="checkbox"/> | <input type="checkbox"/> | |
| Working at heights | <input type="checkbox"/> | <input type="checkbox"/> | |
| Wearing Personal Protective equipment: | <input type="checkbox"/> | <input type="checkbox"/> | |
| • steel capped safety boots | <input type="checkbox"/> | <input type="checkbox"/> | |
| • protective gloves | <input type="checkbox"/> | <input type="checkbox"/> | |
| • safety glasses or goggles | <input type="checkbox"/> | <input type="checkbox"/> | |
| • ear muffs or plugs | <input type="checkbox"/> | <input type="checkbox"/> | |
| • safety helmet | <input type="checkbox"/> | <input type="checkbox"/> | |
| • respiratory mask | <input type="checkbox"/> | <input type="checkbox"/> | |
| • full safety harness | <input type="checkbox"/> | <input type="checkbox"/> | |
| Lifting more than 20kg | <input type="checkbox"/> | <input type="checkbox"/> | |
| Rotation of your head from side to side | <input type="checkbox"/> | <input type="checkbox"/> | |
| Gripping firmly with both hands | <input type="checkbox"/> | <input type="checkbox"/> | |
| Using vibrating hand tools | <input type="checkbox"/> | <input type="checkbox"/> | |
| Using general hand tools | <input type="checkbox"/> | <input type="checkbox"/> | |
| Repetitive movements of the hands or arms | <input type="checkbox"/> | <input type="checkbox"/> | |
| Shift work | <input type="checkbox"/> | <input type="checkbox"/> | |
| Confined spaces | <input type="checkbox"/> | <input type="checkbox"/> | |
| Reading ordinary newsprint | <input type="checkbox"/> | <input type="checkbox"/> | |
| Understanding written English | <input type="checkbox"/> | <input type="checkbox"/> | |
| Understanding verbal English | <input type="checkbox"/> | <input type="checkbox"/> | |
| Bending repetitively | <input type="checkbox"/> | <input type="checkbox"/> | |
| Hearing in a normal conversation | <input type="checkbox"/> | <input type="checkbox"/> | |
| Kneeling | <input type="checkbox"/> | <input type="checkbox"/> | |
| Sitting constantly for 2 hours | <input type="checkbox"/> | <input type="checkbox"/> | |
| Standing constantly for 2 hours | <input type="checkbox"/> | <input type="checkbox"/> | |

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