MEDICAL ASSESSMENT – ADULT

Date of Medical

TMA100

CLIENT TO READ AND COMPLETE PLEASE

The primary purpose of this medical is not to pass or fail. It is to anticipate any potential medical issues which may occur so that appropriate measures may be taken to lower your risk. A summary of this information may be required by your employer or the agency responsible for your medical care while overseas. No information will be sent without your signed consent for release, which follows at the end. You can withdraw consent at any time in writing.

Your Details (PLEASE USE BLOCK LETTERS/PRINT NEATLY)

Name (first) | (last)

Date of Birth | M/F | Occupation

Location Overseas | Employer while overseas/Aid Agency

Home Address

Phone (daytime) | Mobile

Email Address

Overseas Position Involves (PLEASE TICK IF YOU HAVE HAD ANY OF THE FOLLOWING) (TICK MORE THAN ONE BOX IF REQUIRED)

- ☐ Physically demanding work
- ☐ Mainly office work
- ☐ Exposure to high temperatures
- ☐ Climbing stairs/ladders
- ☐ Frequently offshore (>3 times/yr)
- ☐ Rarely offshore (<3 times/yr)
- ☐ Helicopter travel
- ☐ Altitude above 2500 metres
- ☐ Medical work
- ☐ Assisting in local schools
- ☐ Humanitarian work
- ☐ Driving motor vehicle
- ☐ Other special activities

(Please state) .....

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Cardiovascular (PLEASE TICK IF YOU HAVE HAD ANY OF THE FOLLOWING) (TICK MORE THAN ONE BOX IF REQUIRED)

- ☐ palpitations
- ☐ high blood pressure
- ☐ raised cholesterol
- ☐ ankle swelling
- ☐ chest pain
- ☐ anaemia
- ☐ other (specify).....
- ☐ heart attack
- ☐ valve problem
- ☐ heart surgery
- ☐ DVT (thrombosis)
- ☐ heart murmur
- no problems..... ☐

Doctor's Notes:

Respiratory (PLEASE TICK IF YOU HAVE HAD ANY OF THE FOLLOWING) (TICK MORE THAN ONE BOX IF REQUIRED)

- ☐ asthma
- ☐ emphysema
- ☐ tuberculosis
- ☐ shortness of breath
- ☐ pneumonia
- ☐ collapsed lung/pneumothorax
- ☐ other (specify).....
- ☐ pleurisy
- ☐ bronchiectatis/bronchitis
- ☐ coughing blood
- ☐ tendency to chest infections
- ☐ pulmonary embolism
- no problems..... ☐

Doctor's Notes:

Gastrointestinal (PLEASE TICK IF YOU HAVE HAD ANY OF THE FOLLOWING)

- ☐ stomach ulcer
- ☐ gall stones
- ☐ unexplained weight loss
- ☐ hepatitis/jaundice
- ☐ haemorrhoids/piles
- ☐ indigestion
- ☐ abdominal pain
- ☐ irritable bowel syndrome
- ☐ hiatus hernia
- ☐ blood in motions
- ☐ frequent nausea, vomiting/vomit blood
- ☐ endoscopy
- ☐ colonoscopy
- ☐ ulcerative colitis/ crohn's disease
- ☐ pancreatitis
- no problems ☐
- ☐ other (specify) .....

Doctor's Notes:

Neurological/Psychological (PLEASE TICK IF YOU HAVE HAD ANY OF THE FOLLOWING)

- ☐ depression
- ☐ anxiety/phobias/compulsions
- ☐ attempted suicide
- ☐ panic attacks
- ☐ epilepsy/fits
- ☐ headaches/migraine
- ☐ deafness
- ☐ insomnia
- ☐ fainting
- ☐ paralysis/stroke
- ☐ referred to psychiatrist/ psychologist
- ☐ head injury/concussion
- ☐ tingling/numbness/pain
- ☐ post traumatic stress disorder
- no problems ☐
- ☐ other (specify).....

Doctor's Notes:

Musculoskeletal (PLEASE TICK IF YOU HAVE HAD ANY OF THE FOLLOWING)

- ☐ arthritis
- ☐ broken bones/sprains
- ☐ muscle weakness
- ☐ repetitive strain injury (RSI)
- ☐ back or neck pain
- ☐ joint surgery
- no problems ☐
- ☐ other (specify) .....

Doctor's Notes:

Skin (PLEASE TICK IF YOU HAVE HAD ANY OF THE FOLLOWING)

- ☐ psoriasis
- ☐ skin cancers
- ☐ herpes
- ☐ eczema/dermatitis
- ☐ other skin problems (specify)

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- ☐ wounds failing to heal
- ☐ recurrent boils
- no problems ☐

Doctor's Notes:

When outdoors, how often do you do the following?	Always	Sometimes	Rarely
Wear a hat			
Wear sunglasses			
Apply sunscreen before hand			
Wear protective clothing			

Genito-urinary (PLEASE TICK IF YOU HAVE HAD ANY OF THE FOLLOWING)

- ☐ chlamydia
- ☐ kidney stones
- ☐ bladder problems
- ☐ blood in the urine
- ☐ urinary tract infection
- ☐ other kidney or urinary problems (specify) .....

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- ☐ sexually transmitted diseases
- ☐ lose urine when cough or laugh
- no problems ☐

Doctor's Notes:

Your Name (full name)

Men only (PLEASE TICK IF YOU HAVE HAD ANY OF THE FOLLOWING)

- ☐ testicular problems
- ☐ prostate problems
- ☐ hernia
- ☐ other (specify) .....
- ☐ significant change in urinary flow
- no problems..... ☐

Doctor's Notes:

Women only (PLEASE TICK IF YOU HAVE HAD ANY OF THE FOLLOWING)

- ☐ irregular periods
- ☐ heavy periods
- ☐ periods stopped
- ☐ menopause
- ☐ breast lumps
- ☐ prone to vaginal thrush
- ☐ other gynaecological problem .....
- ☐ problems with previous pregnancies
- ☐ pregnant or planning
- ☐ currently breastfeeding
- no problems..... ☐

Doctor's Notes:

Other (PLEASE TICK IF YOU HAVE HAD ANY OF THE FOLLOWING)

- ☐ diabetes – on insulin (_)
  – on tablets (_)
  – diet controlled (_)
- ☐ immune weakness
- ☐ cancer of any sort
- ☐ thyroid problem
- ☐ chronic fatigue
- ☐ clotting problems
- ☐ Thrombosis or DVT

Have you ever had life insurance declined or accepted on special terms? y n

Doctor's Notes:

Glasses (PLEASE TICK IF YOU HAVE HAD ANY OF THE FOLLOWING)

If you wear glasses or contact lenses, please indicate below.
Tick more than one box if required.

- ☐ Glasses for near vision only eg reading
- ☐ Glasses for distant vision only
- ☐ Glasses for all distances
- ☐ Contact lenses

Last optometrist or eye specialist review m yr

Doctor's Notes:

Dental

When was your last dental check? m yr

Is there futher dental work pending? y n

Comments.....

If your last dental check was more than six months ago, you are strongly encouraged to have a checkup prior to departure. Dental abcesses are very painful and emergency dental treatment while overseas is inconvenient, expensive and not always safe. Some companies require you have a documented 'Dental Clearance' for this reason.

Doctor's Notes:

Diet

Are you currently following, or planning to start, a special type of diet or a restricted diet?

☐ No ☐ Yes (please state).....

How many portions do you have per day: Fruit..... Vegies .....

Examples of a single portion:

Fruit
- *1 medium size apple, banana, orange or quarter rockmelon*
- *half cup of fruit juice*
- *4 dried apricots or 1½ tablespoons of sultanas*

Vegetables
- *half cup of cooked vegetables (75g)*
- *1 medium potato*
- *1 cup of salad vegetables*

On average how many cups of coffee, tea, coke or other caffeinated drinks do you consume per day? # cups/glasses per day

Doctor's Notes:

Your Name (full name)

Weight

Do you feel your current weight is about right for you? y n

Have you lost or gained weight in the last 5 years? y n

Do you often think about your weight and or body size? y n

Have you ever been told you have an eating disorder (anorexia, bulimia)? y n

Doctor's Notes:

Exercise

Please tick which type of exercise do you do in a typical week?

- ☐ No regular exercise
- ☐ Jogging
- ☐ Brisk walking
- ☐ Gymnasium workout
- ☐ Other (state) .....

Average session is ☐ minutes ☐ times per week

Doctor's Notes:

Smoking

Which best describes your smoking history?

- ☐ Never smoked regularly
- ☐ Ex-smoker: average ☐ packs per day for ☐ yr years
- ☐ Current smoker from age ☐ yr
- ☐ Are you interested in quitting smoking y n

If you are a current smoker please complete the following.

Doctor's Notes:

THE FAGERSTROM TEST FOR NICOTINE DEPENDENCE

Please circle the answer which is most appropriate.

1. How soon after you wake up do you smoke your first cigarette?
   a) Within 5 minutes 3
   b) 5–30 minutes 2
   c) 31–60 minutes 1
   d) over 60 minutes 0
2. Do you find it hard to refrain from smoking in places where it is forbidden?
   a) Yes 1
   b) No 0
3. Which cigarette would you most hate to give up?
   a) The first one in the morning 1
   b) Any other 0
4. How many cigarettes do you smoke a day?
   a) 10 or less 0
   b) 11 – 20 1
   c) 21 – 30 2
   d) Over 30 3
5. Do you smoke more frequently during the first hours after waking than during the rest of the day?
   a) Yes 1
   b) No 0
6. Do you smoke if you are so ill that you are in bed most of the day?
   a) Yes 1
   b) No 0

TOTAL SCORE:

DEPENDENCE LEVELS FAGERSTROM TEST

Score	*Rating*
0 to 2	Very Low Dependence
3 to 4	Low Dependence
5	Medium Dependence
6 to 7	High Dependence
8 to 10	Very High Dependence

EPWORTH SLEEPINESS SCALE

Scale: 0 = would never doze or sleep
1 = slight chance of dozing or sleeping
2 = moderate chance of dozing or sleeping
3 = high chance of dozing or sleeping

Situation	Chance of Dozing or Sleeping			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place	0	1	2	3
Being a passenger in a motor vehicle for an hour or more	0	1	2	3
Lying down in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (no alcohol)	0	1	2	3
Stopped for a few minutes in traffic while driving	0	1	2	3

TOTAL SCORE:

EPWORTH SCORE

Score	*Rating*
0 – 9	Normal
> 10	Need sleep review

Medications

Please list any prescription and non-prescription medication which you use regularly or as required. Include inhalers, patches, laxatives, fluid tablets, weightloss medication, prescription creams, vitamins and 'quit smoking' medication.

I take no medication ☐ I take list below (Name & Dose) ☐

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Doctor's Notes:

Alcohol & Recreational Drugs

Please estimate your average weekly alcohol consumption in standard units.

1 unit = 30ml measure of spirits 120ml glass of wine
285ml glass of beer 60ml glass of sherry

Estimates total units per average week ☐ units.

How many alcohol free days do you have per week ☐ d .

How often do you have six or more drinks on one occasion?

☐ Never ☐ Monthly or less
☐ Weekly ☐ Daily or almost daily

In the last 12 months have you used Marihuana or other recreational drugs? y n

Doctor's Notes:

Allergies

(Tick more than one if applicable)

I have no known allergies..... n

☐ I get hayfever/eczema/asthma

☐ I am allergic to .....

☐ I have a serious or life threatening allergy to

.....

☐ I have previously required adrenaline (Epinephrine/Epipen) or hospitalisation for an allergic reaction

☐ I carry adrenaline (eg Epipen) when travelling

Doctor's Notes:

Illness/Injuries/Surgery

Have you ever had surgery to remove any body parts? y n

If yes please tick:

☐ tonsils ☐ appendix ☐ spleen ☐ breast

☐ other *(please name)* .....

Have you had a fall in the last year? y n

If yes what happened: .....

.....

.....

Have you been absent from work in the last 5 years due to illness, injury or a surgical operation? y n

If yes please outline .....

Have you been referred to a specialist in the last 5 years? y n

If yes please outline .....

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Doctor's Notes:

Occupational Health

Have you been exposed to any known occupational hazards? y n

If yes please circle

noise, radiation, dusts, asbestos, lead, other chemicals

Have you been required to use any of following at work in the past? y n

if yes please circle

protective clothing, safety glasses, hearing protection

Have you ever developed any medical condition in connection with your occupation? y n

if yes please circle

hearing loss , skin condition, wheeze, backache, muscle strain, blood disease

Have you ever suffered an industrial injury or accident? y n

Have you ever been medically evacuated from an offshore installation? y n

Have you ever been rejected from employment on medical grounds? y n

Have you ever received compensation, or are there any industrial claims pending? y n

Doctor's Notes:

Screening Tests

Have you had a skin cancer check? y n

If Yes when: m yr

☐ Normal

☐ Abnormal (please state) .....

Have you had a faecal occult blood test? y n

If Yes when: m yr

☐ Normal

☐ Abnormal (please state) .....

Have you had a test for HIV AIDS in the last 5 years? y n

Doctor's Notes:

Women Only Tests (Leave blank if never had) * *please attach copies if available*

Last Pap Smear* m yr

☐ Normal

☐ Abnormal .....

Last Breast Mammogram* m yr

☐ Normal

☐ Abnormal .....

Last bone density test?* m yr

Doctor's Notes:

Psychological

During the past month, have you often been bothered by feeling down, depressed or hopeless? y n

Overseas placement can be demanding and problems with adjustment to culture, travel, separation from family etc can sometimes occur. Do you have any particular concerns regarding your ability to adjust to these demands? y n

Doctor's Notes:

Your Name (full name)

Family History

Do you have a parent or sibling with any of the following?

- ☐ Male heart disease below age 55
- ☐ Female heart disease below age 65
- ☐ DVT/Thrombosis/Lung embolism
- ☐ Stroke
- ☐ Bowel Cancer
- ☐ Breast Cancer
- ☐ Diabetes
- ☐ Schizophrenia/Mania/Depression
- ☐ Alcohol problem
- ☐ Other health problems that run in the family

Comments .....

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..... None of the above ☐

Doctor's Notes:

Other Concerns

Do you have concerns regarding any problems we have not asked about or other health issues which might occur while you are away? (If so, the doctor will discuss these with you). y n

If Yes (please state).....

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Doctor's Notes:

THANK YOU

PLEASE ENSURE YOU HAVE WRITTEN YOUR NAME ON THE TOP OF EACH PAGE

PLEASE REMEMBER TO BRING TO YOUR APPOINTMENT THIS COMPLETED FORM AND MEDICAL RECORDS/REPORTS, ECG, X-RAY AND FOR WOMEN PAP SMEAR/MAMMOGRAM RESULTS, UNDERTAKEN IN THE LAST 3 YEARS.

AUTHORITY TO RELEASE RESULTS

I have completed the above information correctly to the best of my knowledge and recollection. I understand that this medical assessment is for the purpose of identifying potential health problems. I authorise the examining doctor to release this report, in part or in full, together with pathology results which may include HIV, Hepatitis and Drug and Alcohol screening and a summary of any vaccinations and medications given, if required, marked 'In Confidence' to:

Organisation you authorise:

I understand this information may be sent by confidential fax if required urgently. In the event of a medical emergency I give permission for my records to be made available to the treating Doctors.

Signature

/ /20

Witness

/ /20