

# Pre-Employment Medical Questionnaire



Main Roads is committed to maintaining a safe and healthy workplace and to maintaining the safety, health and wellbeing of all employees.

By providing the following information, you will assist Main Roads to ensure that you or others are not at risk, whilst conducting your work activities.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

DOB: \_\_\_\_\_

Email: \_\_\_\_\_

Name of Doctor: \_\_\_\_\_

Practice name and address: \_\_\_\_\_

\_\_\_\_\_

Doctor/Practice telephone number: \_\_\_\_\_

## Q1. Do you have or have you ever had any of the following conditions?

Medical Condition	Y	N	Comments
Eyesight or hearing impairments			
Diabetes			
Epilepsy, Migraine Headaches, Loss of consciousness			
Any back or neck condition/injury			
Allergies			
Repetitive Strain Injury, Occupational Overuse Syndrome e.g. Carpal Tunnel Syndrome, Tendonitis			
Mental ill health and or stress related conditions			
Any condition which limits bending, lifting, standing or squatting			
Arthritis, Stiffness/soreness of joints			

**Q2. Apart from the medical conditions listed above, have you suffered a medical condition, disability or serious injury within the last 10 years that may affect your work performance or could be aggravated, by you undertaking the requirements of the position for which you are applying?**

No (Please proceed to Q4.)

Yes (Please complete Q3.)

**Q3. Please complete if responding “Yes” to Q2:** How long have you been aware of the above and what treatment/s are you receiving?

- 1 \_\_\_\_\_ (Year/Months) | Treatment: \_\_\_\_\_
- 2 \_\_\_\_\_ (Year/Months) | Treatment: \_\_\_\_\_
- 3 \_\_\_\_\_ (Year/Months) | Treatment: \_\_\_\_\_

**Q4. Are you currently taking any medication, prescribed or otherwise, which may cause side effects such as drowsiness, slows reflexes/reactions, impairs judgement or that must be taken in accordance with a medical practitioner’s advice?**

No

Yes (If yes, please specify the name of the medication/s and the potential side effects.)

Medication: \_\_\_\_\_

**Q5. Do you require any adjustments to your workplace, work design or require specific equipment, to perform in the proposed position?**

No

Yes (if yes please specify)

\_\_\_\_\_  
 \_\_\_\_\_

**Q6. Are you aware of any other medical or physical reason why you may not be able to completely perform the normal duties associated with the position for which you are applying?**

No

Yes (if yes please specify)

\_\_\_\_\_  
 \_\_\_\_\_

**Q7. If you have a disability or impairment, please provide any special considerations that need to be taken into account for your work environment.**

I authorise Main Roads to contact my treating doctor(s) to seek medical clearance when a pre-existing injury or illness has been declared and is relevant to my capacity to undertake the role for which I am applying.

I declare that to the best of my knowledge, the above statements are true and correct in all respects and I have not withheld any relevant information. I acknowledge that any false or misleading information may result in disciplinary action and potential termination of employment.

**Full Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_