BLUESTAR GLOBAL LOGISTICS	BlueStar Logistics	Version: 0.1 Date: 110712
	Health Assessment Questionnaire	

Site	
Name	
Position Application	
Date	

Section 1		YES	NO
1.1	Do you have any health problems that could affect your ability to perform this job? *If YES please list further information*		
1.2	Have you ever been refused life insurance, military service or a job due to poor health?		
1.3	Do you have any difficulty lifting weights?		
1.4	Have you ever had a work-related injury or illness? *If YES please list further information*		
1.5	Have you ever been told that your hearing is reduced after having a hearing test?		
1.6	Do you wear glasses? *If YES complete the following by circling the selection that suits your eyesight:* For reading only For Distance Only Always		
1.7	Do you have any problem that prevents you from wearing safety footwear, safety glasses, ear muffs or ear plugs or any other safety equipment? *If YES please list further information*		
1.8	Have you ever tested positive in any workplace drug & alcohol screening test?		
1.9	Are you currently being treated by a health professional? *If YES please list further information*		

Section 2 Have you ever had or are you currently being treated for any of the following		YES	NO
2.1	Allergies to food, medications or chemicals		
2.2	Work-related stress		
2.3	Head injury, stroke		
2.4	Dizziness, faints, fits, epilepsy, blackouts, poor balance		
2.5	Hearing loss, past ear operations, ringing in the ears		
2.6	Asthma		
2.7	Mental Illness		
2.8	TB, emphysema, collapsed lung, any other lung diseases		
2.9	Sinusitis, hay fever		
2.10	Hernia, bowel disease		
2.11	Peptic ulcer, jaundice, liver disease		
2.12	Diabetes, kidney problems, thyroid disease		
2.13	Heart condition, angina, high blood pressure, pace maker		
2.14	Varicose veins		
2.15	Hepatitis, HIV or other serious infectious disease		
2.16	Chronic muscle pains, RSI		
2.17	Arthritis, joint problems, gout		
2.18	Carpal tunnel, wrist injury, ganglion, hand/finger problem		
2.19	Shoulder or elbow injury or pain		

Section 2 Have you ever had or are you currently being treated for any of the following		YES	NO
2.20	Intolerance to smoky environments		
2.21	Whiplash, neck injury or pain		
2.22	Slipped disc, sciatica, back injury or chronic pain		
2.23	Knee or hip injury or pain		
2.24	Foot problems		
2.25	Broken or fractured bones		
2.26	Pain and/or restricted kneeling or squatting		
2.27	Pain and/or restricted bending your back, reaching up		
2.29	Dermatitis, eczema, rashes, psoriasis		
2.30	Exposure to excessive dust, asbestos, toxic chemicals		
2.31	Exposure to loud noise – occupational or recreational		
2.32	Depression, anxiety or other nervous problems		

If you have answered YES to any of the above please provide further information (what, when and how?)

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Section 3		YES	NO
3.1	Do you use sedatives or drugs that may cause drowsiness? *If YES please list further information*		
3.2	Do you use any regular medications? *If YES please list further information*		
3.3	Have you ever had a reaction to chemicals or dust in the workplace? *If YES please list further information*		
3.4	Have you been medically advised to limit or restrict your activities *If YES please list further information*		
3.5	Are you currently attending a physiotherapist, chiropractor, osteopath, acupuncturist or a practice of these trades? *If YES please list further information*		
3.6	Have you ever had a muscle, tendon or ligament injury? *If YES please list further information*		
3.7	Have you ever had a sporting injury? *If YES please list further information*		
3.8	Have you ever had any medical treatment on any party of your body that has made you unable to bend, squat or lift? *If YES please list further information*		

Section 4 Do you have any condition that may make you unfit, or at an increased risk at work		YES	NO
4.1	Alcohol or drug misuse		
4.2	Loss of mobility		
4.3	Dizziness with heights		
4.4	Panic when closed in		
4.5	Hearing impairment		
4.6	Loss of bodily function		
4.7	Psychological problem		
4.8	Panic with height		
4.9	Vision impairment		
4.10	Other		

If you have answered YES to any of the above please provide further information (what, when and how?)

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Section 5 Do you have any difficulty with the following activities		YES	NO
5.1	Sitting or standing in excess of 2 hours?		
5.2	Turning your head rapidly?		
5.3	Using hand tools?		
5.4	Concentrating for any length of time?		
5.5	Hearing a normal conversation?		
5.6	Reading ordinary print?		
5.7	Climbing a ladder?		
5.8	Crouching?		
5.9	Lifting or bending?		
5.10	Gripping firmly with either or both hands?		
5.11	Repetitive movements of the head?		
5.12	Repetitive movements of the arm?		

If you have answered YES to any of the above please provide further information (what, when and how?)

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Declaration

I, ..., acknowledge that the information requested and contained in this form is true & correct and will be held by BlueStar Logistics in the strictest confidence and in accordance with the Privacy Act 2000. I understand that if my information is not true and correct that this could place either myself or others at risk in the workplace. I further acknowledge, providing false and misleading information on this form may constitute serious misconduct and disciplinary action may be taken against me up to and including termination of employment.

Signature..... Date.....

Office Use Only			
Checked By:		Date:	