BP Kwinana Refinery
Pre-Employment Medical Assessment

Please answer each question. If in doubt, leave blank and consult the nurse or doctor.

Date of this assessment:

Personal Details

Last Name	First Names		Date of Birth
Nationality	Gender (Circle one) M / F	Employer Name	BP Position Applied For
Home Address			Contact Number Mobile
Next of Kin			Contact Number

Employment History

What is your current job?

Who is your present employer?

Where have you worked in the past and what did this involve?

From (Year)	To (Year)	Employer Name	Location	What did you do?

Exposure History

If you have worked in any of these jobs, please tick yes and provide information.

Asbestos Removal	Yes ☐ No ☐	Primary Industry	Yes ☐ No ☐
Ship Building	Yes ☐ No ☐	Grains/silos or baking	Yes ☐ No ☐
Building or construction work	Yes ☐ No ☐	Mining	Yes ☐ No ☐
Plumbing or lagging work	Yes ☐ No ☐	Flour Milling	Yes ☐ No ☐
Demolition work	Yes ☐ No ☐	Foundry	Yes ☐ No ☐
Paint Manufacturing	Yes ☐ No ☐	Carpentry or woodwork	Yes ☐ No ☐

Please give more information if you ticked yes to one or more item. ……..
……
……
……

Other occupational exposure history

If you have been exposed to any of the following please provide information. Please tick no if it does not apply.

Ionising radiation	Yes ☐ No ☐	Asbestos/Solvents	Yes ☐ No ☐
Chemicals	Yes ☐ No ☐	Noise	Yes ☐ No ☐

Please give more information if you have ticked yes to one or more item…….....
……
……

Personal Health

Date of last Tetanus/ADT…… Hepatitis A…….. Hepatitis C……

Do you have a physical disability? ☐ Yes ☐ No
(If yes, please provide details)
……

Do you have any allergies? ☐ Drugs ☐ Food ☐ Allergy ☐ Hayfever/ Seasonal
(If yes, please provide details)
……
……

Have you ever being diagnosed with Cancer? ☐ Yes ☐ No

If yes, please explain……
……

How long ago? …… Treatment ……..

Have you made a Workers Compensation Claim in Australia? ☐ Yes ☐ No

If yes, please provide details of injury or illness details including month/year and if the claim has been finalised.
……
……

Medications

Do you take any medication? Yes ☐ No ☐

Prescribed Yes ☐ No ☐

Unprescribed Yes ☐ No ☐

Please specify……

Smoking Habits

Never Smoked ☐

Ex-Smoker ☐ If yes years Smoked …… Number smoked …… Year stopped ……..

Current Smoker ☐ If yes years smoked ……... Number smoked ……

For smokers only: Are you interested in quitting? Yes ☐ No ☐

Heart and Circulation

☐ Heart Attack/Heart Disease
☐ Heart/Chest Surgery
☐ Stent/s
☐ Chest Pains/Angina/Palpatations
☐ Stroke
☐ Irregular or Rapid heartbeat
☐ Enlarged Heart
☐ Varicose Veins/Deep vein thrombosis
☐ Other
☐ **None of the above**

If yes, please explain……..
……..…

Endocrine System

☐ Diabetes ☐ Type 1 ☐ Type 2

If Type 1, please state medications as prescribed.

Please provide evidence of HbA1c Test!

Treating Doctor ……..……..…

Date of most recent ophthalmology review ……

Date of most recent driving review ……..

Class of Licence …… ☐ Conditional ☐ Not conditional

If Type 2 Diabetic please state medications as prescribed if any? ……

☐ Thyroid dysfunction
☐ Pituitary dysfunction
☐ Pancreatitis
☐ **None of the above**
☐ Addison's/Cushing's Disease
☐ Lupus
☐ Other

Respiratory

☐ Asthma
☐ Rheumatic Fever
☐ Shortness of Breath
☐ **None of the above**
☐ Bronchitis/Pneumonia/pleurisy
☐ Tuberculosis
☐ COPD (Chronic Obstructive Pulmonary Disease)

Have you ever been hospitalised for any of the above conditions? Yes ☐ No ☐

If yes, please explain
……
……..…
……..…

Do you cough first thing in the morning? Yes ☐ No ☐

If yes, please explain……..

Do you usually cough during the day or night? Yes ☐ No ☐

How long have you had this cough? ☐ < 2 years ☐ 2-9 years ☐ 10+ years

Have you ever been told you snore? Yes ☐ No ☐

Have you ever had an accident as a result of blacking out? Yes ☐ No ☐
Has a Doctor ever told you that you have a sleep disorder? Yes ☐ No ☐

Has a Doctor ever told you have sleep apnoea? Yes ☐ No ☐

Do you have any conditions that may affect your ability to perform in the role applied for? Yes ☐ No ☐

If so, please explain ……
……

Vision

☐ Abnormal night vision
☐ Blurred vision
☐ Burning/tearing/redness of eyes
☐ Cataracts
☐ Eye allergies or infections
☐ Eye Surgery
☐ Colour Blindness
☐ Wear glasses or contacts
☐ Other
☐ **None of the above**

If yes, please explain……

Do you wear prescription glasses? Yes ☐ No ☐

If so, over what period of time? ……

General Body

☐ Liver or gall bladder problems
☐ Stomach, duodenal or peptic ulcer
☐ Bleeding from the rectum
☐ Kidney stone or renal colic
☐ Unexpected weight loss
☐ Hernia
☐ Kidney disease
☐ Bowel Problems
☐ Other
☐ **None of the above**

If yes, please explain……

Skin

☐ Cracking/bleeding
☐ Skin discolourations
☐ Psoriasis/Eczema
☐ Skin allergies/rashes
☐ Itching/peeling
☐ Dermatitis reaction to jewellery/nickel etc
☐ Other
☐ **None of the above**

If yes, please explain……

Ear, Nose, Throat and Dental Problems

☐ Ear Discharge
☐ Ringing in ears
☐ Ear Surgery
☐ Ear aches
☐ Sinus problems
☐ Swollen Lymph Glands
☐ Dental problems
☐ Other

☐ Hearing difficulties

☐ **None of the above**

If yes, please explain……

Musculoskeletal

☐ Arthritis/Gout/Rheumatism
☐ Back Injury
☐ Back pain
☐ Back surgery
☐ Joint swelling
☐ Knee problems
☐ Elbow complaints
☐ Carpal Tunnel Syndrome
☐ Neck pain/whiplash
☐ Muscular or tendon problems
☐ Broken bones, dislocation
☐ Hand injury/complaint
☐ Wrist injury/complaint
☐ Finger injury/complaint
☐ Other
☐ **None of the above**

If yes, please explain ……

Other

Please tick yes if you have had any difficulties with any of the following.

Plant and site access:
☐ Ladders
☐ Multiple stairs
☐ Uneven ground
☐ Climbing
☐ Working at heights

Safety:
☐ Use of personal protective equipment
- safety glasses, boots, suits, monogoggles
☐ Emergency response
☐ Communication problems
☐ Hand/eye coordination
☐ Use of a respirator

Work Environment and Manual Hazards:
☐ Confined Spaces
☐ Work in isolation
☐ Shift work
☐ Vibration
☐ Outdoor work
☐ Hot/cold conditions
☐ Kneeling/Squatting
☐ Overhead work
☐ Awkward postures
☐ Low level work
☐ Pushing, pulling, reaching
☐ Prolonged sitting/standing
☐ Fear of Heights
☐ Other

Physical Abilities:
☐ Running 100 metres
☐ Climbing a ladder
☐ Walking on rough ground
☐ Crouching
☐ Lifting >15 kgs
☐ Turning your head
☐ Gripping firmly with both hands
☐ Repetitive movements of hands/arms
☐ Hearing normal conversation
☐ Reading ordinary newsprint
☐ Concentration
☐ Smelling odours
☐ Fear of closed spaces
☐ **None of the above**

If yes, please provide details……
……
……

General Health

☐ Persistent fever
☐ Sweating at night
☐ Fits, faints or funny turns
☐ Epilepsy
☐ Alcohol or drug problem
☐ Anxiety
☐ Depression
☐ Mental or nervous disorder

☐ Dizziness
☐ **None of the above**

Are you currently suffering from any injury/illness?
Yes ☐ No ☐

If yes, please explain ……

Is the above injury/illness Work related?
Yes ☐ No ☐

Have you previously suffered from an injury/illness?
Yes ☐ No ☐

If yes, please provide details including the date/year……
……
……
……

Fitness to work in a hot environment

Have you ever worked in a very hot environment before? Yes ☐ No ☐

Please Specify……

Have you had any previous adverse reaction to working in a very hot environment? Yes ☐ No ☐

Please specify……

Have you ever had a heat related illness? (heat stroke, heat exhaustion) Yes ☐ No ☐

Please specify……

Have you ever experienced a loss of consciousness, seizures (fits) or fainted? Yes ☐ No ☐

Please specify……

Do you have diabetes, thyroid problems or other hormonal conditions? Yes ☐ No ☐

Please specify……

Have you ever been diagnosed with cardiovascular disease or high blood pressure? Yes ☐ No ☐

Please specify……

Have you ever had lung problems, shortness of breath or asthma? Yes ☐ No ☐

Please specify……

Are you prone to any skin problems, including dermatitis or infections? Yes ☐ No ☐

Please specify……

Have you had treatment that reduces your capacity to sweat? (Sympathectomy) Yes ☐ No ☐

Please specify……

Are you taking any prescribed or over the counter medications? Yes ☐ No ☐

Please specify……

Have you ever suffered from renal colic, kidney stones or bladder stones? Yes ☐ No ☐

Please specify……

Declaration and Consent

I hereby declare that all statements made and all answers given in this questionnaire are true and complete to the best of my knowledge. I hereby give my consent to any medical practitioner who has undertaken this medical examination to disclose to BP Kwinana Occupational Health relevant medical information for the purpose of this assessment.

I understand that

- The information collected in this form is for the purpose of assessing my suitability for undertaking a role requiring the safe use of respiratory protection in a refinery environment. (Applicable for Respiratory Protection Medicals only)
- My health information will not be disclosed to any agency outside BP, or non-health centre staff within BP without your written authorisation or unless required of authorised by law.
- My health information is maintained as secure and confidential at the BP Kwinana Occupational Health Service, under the director on the BP Kwinana Occupation physician.
- The supply of information in this form is voluntary but failure to supply any information BP deems necessary for you to provide, or providing false and misleading information, may affect your employment application or may have occupation health and safety implications.
- My health information may be included in group reports, but my own data will not be identifiable: and
- I am able to access information about my health from BP Kwinana Occupation Health

Signature…… Date……..…

Physical Examination

Height: ……/cm. Weight: ……/kg.

BMI: ……..

Blood Pressure/Pulse (Sitting)

Pulse: ……/min Regular/Irregular

1st	2nd (20 mins later)
systolic / diastolic	systolic / diastolic

For any higher/irregular results please ascertain whether this is being monitored by a regular GP ……..
……

Resting ECG – 12 lead

☐ Normal ☐ Abnormal

If abnormal, please state characteristics & plan
……

Audiometry

☐ Completed & Attached ☐ Not Completed

Spirometry

☐ Normal (FEV1 >80%, FEV1/FVC >70%) ☐ Abnormal (FEV1 <80%, FEV1/FVC <70%)

☐ Completed & Attached ☐ Not Completed

Vision

	Uncorrected		Corrected	
Distance	Right 6/	Left 6/	Right 6/	Left 6/
Near	N	N	N	N

Correction: ☐ None ☐ Spectacles ☐ Contact Lenses ☐ Laser Surgery

Ishihara ☐ Normal ☐ Red/Green – Total ……

Visual Fields ☐ Normal ☐ Abnormal ☐ Not examined

Urinalysis

☐ NAD ☐ Protein …….. ☐ Glucose ……. ☐ Blood …… ☐ Other ……..

Urine Drug Screen Results

Date…… Time ……Tester: ……..

Results: ☐ Negative

☐ Non Negative ☐ Sent for GCMS

Medical Assessment - Observations

Cyanosis	☐ Present		☐ Not examined
Clubbing	☐ Present		☐ Not examined
Trachea Midline	☐ Present		☐ Not examined
Heart sounds	☐ Normal		☐ Not examined
Lungs - percussion note	☐ Normal		☐ Not examined
Lungs – air entry	☐ Normal		☐ Not examined
Lungs – added sounds	☐ Present		☐ Not examined
Peripheral arteries	☐ Normal		☐ Not examined
Abdomen Palpation: Result			☐ Not examined
Herniae	☐ Present		☐ Not examined

Location: .....

Lymph Nodes	☐ Present		☐ Not examined

Location: .....

Skin	☐ Normal	☐ Abnormal	☐ Not examined
Fundi	☐ Normal	☐ Abnormal	☐ Not examined

Range of Movement

Spinal Column	☐ Normal	☐ Restricted	☐ Not examined
Shoulder ROM	☐ Normal	☐ Restricted	☐ Not examined
Elbow ROM	☐ Normal	☐ Restricted	☐ Not examined
Wrist ROM	☐ Normal	☐ Restricted	☐ Not examined
Hip ROM	☐ Normal	☐ Restricted	☐ Not examined
Knee ROM	☐ Normal	☐ Restricted	☐ Not examined
Ankle ROM	☐ Normal	☐ Restricted	☐ Not examined

Doctors Notes.....

.....

.....

.....

.....

Assessment

Fit for proposed position: ☐ Yes ☐ No - Requires further medical assessment/investigations before a recommendation can be given.

……

……

Respiratory Protection Assessment

☐ **UNRESTRICTED** - Able to work in a refinery environment and able to wear respirators without restrictions
☐ **RESTRICTED** - Able to undertake the above subject to restrictions below

1.
2.
3.

☐ Requires further medical assessment/investigations before a recommendation can be given.
(If yes, please list clinical indications, and to whom referral is being made)

……

……

Stress ECG - ERG ONLY (i.e.: All Operations personnel)

History		
Symptoms		
Medication		
Resting ECG		
Exercise time		**Symptoms:**
Exercise in mets		
Target HR		
BP		**Reason for stopping:**
HR		
ST changes		

☐ **UNRESTRICTED** - Able to work in a refinery environment and able to wear respirators without restrictions
☐ **RESTRICTED** - Able to undertake the above subject to restrictions below

1.
2.
3.

Comments/Recommendations: ……

……

HEAT QUESTIONNAIRE ASSESSMENT

☐ **No identifiable risk factors for heat tolerance**
☐ **Possible at risk of heat intolerance**

Comments/Recommendations:……

……

Examining Doctor's Name: (print)	Address:
Signature	Date