



Government of **Western Australia**
 Department of **Mines and Petroleum**
 Resources Safety

Resources Safety
 303 Sevenoaks Street, Cannington WA 6004

Phone: 08 9358 8461

www.dmp.wa.gov.au/ResourcesSafety
 minehealthreporting@dmp.wa.gov.au

HEALTH ASSESSMENT FORM

MINES SAFETY AND INSPECTION ACT 1994 Section 75 (1)

TYPE OF HEALTH ASSESSMENT:

INITIAL

PERIODIC

Health Surveillance Number

(To be assigned by DMP)

PLEASE PRINT IN BLOCK LETTERS

EMPLOYEE'S PERSONAL DETAILS (AS PER CURRENT ID)

Surname: MALE FEMALE
 (include former name, if name has changed)

Given names: Date of birth:/...../.....

Contact address:
 (Health Surveillance Card will be sent to this address) Post code:

Home/Mobile Number:
 (Mandatory)

Name and address of private doctor:
 Post code:

Signature: Date:/...../.....

EMPLOYER DETAILS (CURRENT)

Company:

Site:

Contact Person:

Address:

Contact Number: Post code:

APPROVED PERSON OR MEDICAL PRACTITIONER DETAILS

Approved Person

Medical Practitioner

Address:

Contact Number (mandatory): Date:/...../.....

Approved Person No. or Provider No.:

**Please send the completed health assessment forms including chest x-ray (if required) to:
 Mines Occupational Physician, Resources Safety, DMP, 100 PLAIN STREET, EAST PERTH WA
 6004.**

SECTION I – WORK HISTORY

To be completed by the approved person or medical practitioner only

Note:

- i. Enter all past work history both mining and non-mining from when you left school.
- ii. Enter specific job descriptions, .e.g air leg operator, plant operator, driller, fitter, truck driver, electrician, laboratory operator, mine manager
- iii. Record duration and “from – to” dates as accurately as possible.
- iv. Minesite column – Enter name of mine; if outside WA specify location; if not a minesite leave blank.

Usual occupation or trade: _____

Description of current occupation / job	Period of Time (fill in either of the following)		Name of employer	Name of minesite
	Duration (yy/mm)	From – To (mm/yy – mm/yy)		
	___/___	___/___ - ___/___		
Previous Jobs (most recent job first)	Period of Time		Name of employer	Name of minesite (use “ u/g ” to indicate if underground)
	Duration (yy/mm)	From – To (mm/yy – mm/yy)		
1.	___/___	___/___ - ___/___		
2.	___/___	___/___ - ___/___		
3.	___/___	___/___ - ___/___		
4.	___/___	___/___ - ___/___		
5.	___/___	___/___ - ___/___		
6.	___/___	___/___ - ___/___		
7.	___/___	___/___ - ___/___		
8.	___/___	___/___ - ___/___		
9.	___/___	___/___ - ___/___		
10.	___/___	___/___ - ___/___		
11.	___/___	___/___ - ___/___		
12.	___/___	___/___ - ___/___		

SECTION II – RESPIRATORY QUESTIONNAIRE

To be completed by the approved person or medical practitioner only

Please instruct the employee to give you quick (spontaneous) answers to the questions listed below.

	YES	NO
Cough		
1. Do you usually cough first thing in the morning?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you usually cough during the day or at night?	<input type="checkbox"/>	<input type="checkbox"/>
If NO to questions 1 and 2, go to question 4. If YES to questions 1 or 2:		
3. Do you have a cough like this on most days for as much as three months each year?	<input type="checkbox"/>	<input type="checkbox"/>
Phlegm		
4. Do you usually bring up phlegm from your chest first thing in the morning?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you usually bring up phlegm from your chest at any other time of day or night?	<input type="checkbox"/>	<input type="checkbox"/>
If NO to questions 4 and 5, go to question 9. If YES to questions 4 or 5:		
6. Do you bring up phlegm like this on most days for as much as three months each year?	<input type="checkbox"/>	<input type="checkbox"/>
7. In the past three years have you had a period of increased cough and phlegm lasting for three weeks or more?	<input type="checkbox"/>	<input type="checkbox"/>
If NO to question 7, go to question 9. If YES to question 7:		
8. Have you had more than one such period?	<input type="checkbox"/>	<input type="checkbox"/>
Breathlessness on activity		
9. Do you get short of breath when hurrying on level ground or walking up a slight hill?	<input type="checkbox"/>	<input type="checkbox"/>
If NO to question 9, go to question 12. If YES to question 9:		
10. Do you get short of breath when walking with other people of your age on level ground?	<input type="checkbox"/>	<input type="checkbox"/>
If NO to question 10, go to question 12. If YES to question 10:		
11. Do you have to stop for breath when walking at your own pace on level ground?	<input type="checkbox"/>	<input type="checkbox"/>
Breathlessness at rest		
12. Do you ever get short of breath at rest?	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you ever wake up in your sleep short of breath?	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
Wheezing		
14. Does your chest ever sound wheezy or whistling?	<input type="checkbox"/>	<input type="checkbox"/>
If NO to question 14, go to question 18. If YES to question 14:		
15. Do you get this on most days or nights?	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever had attacks of shortness of breath with wheezing?	<input type="checkbox"/>	<input type="checkbox"/>
If NO to question 16, go to question 18. If YES to question 16:		
17. Was your breathing normal between attacks?	<input type="checkbox"/>	<input type="checkbox"/>
Breathing Difficulty		
18. Does your chest ever feel tight or your breathing become difficult?	<input type="checkbox"/>	<input type="checkbox"/>
Smoking History		
19. Do you, or did you, smoke more than 1 cigarette/day; a cigar/week; or 2 oz (50g) pipe tobacco/month for at least one year?	<input type="checkbox"/>	<input type="checkbox"/>
If NO to question 19, go to question 23. If YES to question 19:		
20a. How much do you (or did you) smoke each day? (no. of cigarettes/cigars)	_____	
20b. Roll-your-owns or pipes (number of grams/week)?	_____	
21. How old were you when you started smoking?	_____	
22. If you are an ex-smoker, how old were you when you gave up smoking permanently?	_____	
Past Chest Illness		
23. During the past three years have you had any chest illness that has kept you from your usual activities for a week or more?	<input type="checkbox"/>	<input type="checkbox"/>
If NO to question 23, go to question 26. If YES to question 23:		
24. Did you bring up more phlegm than usual during this illness?	<input type="checkbox"/>	<input type="checkbox"/>
25. Have you had more than one illness like this in the past three years?	<input type="checkbox"/>	<input type="checkbox"/>
26. Have you ever had asthma?	<input type="checkbox"/>	<input type="checkbox"/>
27. Have you ever had any other chest illness, injury or surgery?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, provide details:		
.....		
.....		
.....		

SECTION III – LUNG FUNCTION TEST

Height _____ (cm) <small>(must be measured)</small>	Age _____ (years)	Weight _____ (kg)
--	-------------------	-------------------

Lung Function (Spirometry)

Room Temp. _____ °C

Make:

Model:

Date of calibration (3-litre syringe) _____ / _____ / _____ Mandatory for all spirometers

Measurement Results:

(attach all spirometry printouts with flow volume graphs to this form)

Three acceptable and reproducible results (within ± 0.15L)

	Test 1	Test 2	Test 3
FEV ₁			
FVC			

Bronchodilator use: Yes No

If yes, how long before test? _____ minutes/hours.

Comments (especially if any difficulty with spirometry):

.....

.....

.....

.....

