MEDICAL ASSESSMENT FORM

(Form to be completed in black ink)

Medical Letter Authorisation No.: | | | | | | | | | | |

Return Date for Medical Feedback Consultation: _____

PERSONAL DETAILS

Surname:			
First Name/s:			
ID No.:		**Date of Birth:**	
Passport No.:		**Sex:**	☐ Male ☐ Female
Contact Address:			
Contact No.'s:			

OCCUPATIONAL HISTORY IN CHRONOLOGICAL ORDER

(Document all the jobs the patient has done, and include times of limited employment, self-employment or unemployment)

#	Employer/Company Name		Job Description	Year Started	Year Ended	Total Time
	Tick if asbestos related job	↓				

Additional Comments:

_____

_____

_____

_____

MEDICAL HISTORY

(Please circle the applicable items, or write, or strike-out items not applicable)

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1) COMPENSATION HISTORY

Have you ever submitted a compensation claim to the MBOD? Yes / No

If submitted: **Status** Compensated / Pending / Rejected

MBOD number _____ **Year Submitted** _____

If compensated: **Diagnosis** _____ **Disability** First Degree / Second Degree

(Where possible please append a copy of the MBOD certification and payment details)

2) SMOKING HISTORY

NEVER SMOKED	Age Started	Age Ended	Years Smoking	No. per Day	Pack-Years
EX-Smoker					
CURRENT Smoker		*n/a*			

Pack-yrs = (Yrs x No.)/20

3) CURRENT AND PAST ILLNESSES

	Year Diagnosed	Details of treatment or management
Asthma / COPD		
Cardiac		
Chest scar (Surgery / Stab / Fracture / Injury)		
Diabetes		
Hypertension		
Tuberculosis (TB)		
Other condition/s:		

4) CURRENT COMPLAINTS:

	Duration	Detail (eg, Pain-type: when, site; Cough-type: when, dry/wet, hemoptysis)
Chest Pain		
Cough		
Dyspnea		
Loss of Weight		
Other		

5) DYSPNEA & EXERTION:

Ask if Dyspneic when: Running / Walking uphill / House-work / Getting Dressed / Just Resting

When walking, what makes you slow down or stop?

Chest Pain	Breathlessness	Leg Pain	Other:

MEDICAL EXAMINATION

(Please circle the applicable items, or write, or strike-out items not applicable)

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1) APPEARANCE

Height in cm _____

Weight in kg _____

Very sick	Sick	Unwell	Well

Very thin	Thin	Normal	Fat	Very fat

Pallor	Cyanosis	Jaundice	Rubor	Odor	Nodes	Clubbing	Edema	Goitre

2) CHEST

Observable dyspnea | Yes | No |

RR _____ *N = 12-18*

Hyperinflation | Yes | No |

Scars: Surgical or Trauma | Yes | No |

Site and Type _____

AUSCULTATION/ PERCUSSION

Detail: Site of abnormality, Inspiratory or Expiratory, Crackles, Rubs, or Wheezes (Dullness or Stony dullness)

_____

_____

_____

3) HEART

BP _____ / _____

PR _____ *N = 60-100*

Irregular | Yes | No |

RV heave	LV heave	Displaced apex

Loud S1	Loud S2

Murmur

Peripheral circulation: _____

4) OTHER RELEVANT OBSERVATIONS / ABNORMALITIES OBSERVED:

Feet	Legs	Abdomen	Legs	Arms	Neck	Face	Mouth	Eyes

ROUTINE TESTS

CXR Date: _____ **Spirometry Date:** _____

Other tests (Specify): _____

(Please ensure all tests are of good or excellent quality, and append them & other relevant reports)

_____

Examining doctor's clinical impression/ assessment: *(eg. Healthy man with well controlled CCF)*

_____

Examined & assessed on (date): _____ **Signed:** _____

Full name, qualifications and address of examining doctor (write or stamp):

_____

_____

_____