Mark the appropriate box with a √	**Employee Name:**	**Company:**	**ID**

PRIMARY HEALTH ASSESSMENT FOR CONSTRUCTION WORKERS

PART 1: HISTORY

1. Marital status: _____

2. Number of children: _____

3. What is your current occupation (the job you do now)?

_____

4. How old are you? _____ years.

5. Are you employed as a:

Casual: ≤ 3days/week	Permanent employee	Contract employee	Sub-Contractor	Management	Other

5.1 If 'Other', please specify: _____

6 Have you, or have you ever had, any of the following? *If 'Yes' please provide full details at the bottom of the page (* BELOW).*		**Answer**	
		Yes	**No**
6.1	Problems with your skin (i.e. rashes, sores)?		
6.2	Problems with your heart?		
6.2.1	Chest pain (angina)?		
6.2.2	High cholesterol level?		
6.2.3	Shortness of breath if you climb stairs?		
6.2.4	High blood pressure (hypertension)?		
6.4	Problems with your lungs?		
6.4.1	Asthma?		
6.4.2	TB?		
6.4.3	Bronchitis?		
6.4.4	Coughing for more than two (2) weeks?		
6.5	Problems with your stomach?		
6.6	Problems with bladder or kidney infections?		
6.6.1	Problems passing water?		
6.6.2	VD (drop)?		
6.7	Epilepsy (fits)?		
6.7.1	Unconscious?		
6.7.2	Headaches or migraines?		
6.8	Problems with your ears?		
6.9	Problems with your eyes?		
6.10	Problems with your throat?		
6.11	Problems with the muscles, bones, joints?		
6.12	Problems with your back?		
6.12.1	Have you ever slipped a disk?		
6.13	Have you ever had any sugar in your urine?		
6.14	Have you ever been tested for HIV/AIDS?		
6.15	Have you ever had yellow jaundice?		
6.16	Cancer or tumours of any kind?		

Mark the appropriate box with a √	**Employee Name:**	**Company:**	**ID**

			Yes	**No**
6.17	Do you take any tablets or medicines on a daily basis, or been given any by Dr or Clinic in past 3 months?			
6.17.1	Type:	Dosage:		
6.17.2	Type	Dosage:		
6.17.3	Type	Dosage:		
6.18	Have you ever been in hospital?			
6.19	Have you ever had an operation?			
6.15	Have you ever had an accident (i.e. sport, car)?			
6.16	Have you ever been injured on duty/while at work?			
6.17	Are there any foods or medicines that cause a rash, itchy skin or make it difficult to breath?			
6.18	Where do you get your medical assistance from: GP? hospital? Clinic?			

***For each of the 'Yes' answers, please provide the following details:**

No.	**When were the last symptoms?**	**Treated by?**	**Specific treatment used**	**Current status**

7. Family history: Do any of your immediate family have or had any of the following illnesses/diseases?

Disease		**Mother**			**Father**		
		Yes	No	Don't know	Yes	No	Don't know
7.1	High blood pressure (Hypertension)						
7.2	Stroke						
7.3	Heart attack						
7.4	Angina (chest pain)						
7.5	Sugar diabetes (Diabetes)						
7.6	Porphyria						
7.7	Mental Illness e.g. Depression requiring hospitalisation						

8. Do you drink any alcohol?

Yes	No

If 'Yes' what types of alcohol do you drink?

Type		**Frequency**				**No. of drinks**		
		Daily	Weekends Only	Monthly/ bi-monthly	Special Occasions	No. of Glasses	No. of Bottles	
							350 ml	750 ml
8.1.1	Beer							
8.1.2	Wine / Fortified wine / Liqueurs							
8.1.3	Spirits							
8.1.4	Other:							

9. Do you smoke?

Yes	No

9.1 How long have you smoked?

Years	

9.2 If 'Yes', what do you smoke?:

Mark the appropriate box with a √	**Employee Name:**	**Company:**	**ID**

Type		**Frequency**			
		Daily	Weekly	Monthly	How many?
9.2.1	Cigarettes				
9.2.2	Pipe				
9.2.3	Dagga				
9.2.4	Other:				

10. Do you play sport

Yes	No

10.1 If 'Yes', what types of sport do you play?

Type		**Frequency**			
		Daily to weekly	Weekends	Monthly	Never
10.1.1	Rugby				
10.1.2	Soccer				
10.1.3	Boxing				
10.1.4	Cricket				
10.1.5	Gym				
10.1.6	Other:				

11. What do you do on your off days/spare time?

Type		**Frequency**			
		Daily	Weekends	Monthly	Never
11.1	Read				
11.2	Watch TV				
11.3	Work at home				
11.4	Church work				
11.5	Other:				

PART 2: PHYSICAL EXAMINATION

L = Left; R = Right 0 = Normal, no abnormality detected
1 = Minor abnormality (minor treatment, no specialist referral)
2 = Major abnormality (specialist referral, impact on lifestyle, possibly work if untreated)

General condition		**Comments**	**Score**
12.1	Height		
12.2	Mass (Weight)		
12.3	Body Mass Index (BMI)		
12.4	Skin		
12.5	Lymph Glands		
12.6	Varicosities		
	Head and Neck:	Comments	
12.7	Corrected Vision (Snellen)	L	R
12.8	Pupils (pearl)	L	R
12.9	Peripheral vision		

Mark the appropriate box with a √	**Employee Name:**	**Company:**	**ID**

	ENT:	**Comments**		**Score**
12.11	Canals	L	R	
12.12	Drums	L	R	
12.13	Sinuses			
12.14	Throat			
12.15	Teeth			

	CVS:	**Comments**	**Score**
12.16	Pulse Rate		
12.17	BP		
12.18	Respiration		
12.19	Thorax and breasts		
12.20	Lungs		
12.21	Heart		
	Abdomen:		
12.22	Organs		
12.23	Masses		
12.24	Hernia		
	Musculo skeletal:		
12.25	Deformities		
12.26	Spine		
	CNS:		
12.27	Power		
12.28	Co-ordination		
	Skin & appendages		
12.29	Hands		
13	**Special Investigations:**	Urinalysis	

13.1		Normal	Glucose	Blood	Protein	Other	Other	Other

13.2	HIV and AIDS		Pre-test Counselling	Post-test Counselling		Other (Note)

14. Remarks from examiner:

15. Referral Requirements (Please record each appropriate organization or person):

15.1	Municipal Clinic	15.3	GP
15.2	Day Hospital	15.4	Specialist

	NAME	**SIGNATURE**	**DATE**
WORKER:			
EXAMINER:			
DOCTOR (If seen):			