



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

Resources Safety  
 303 Sevenoaks Street, Cannington WA 6107

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 “ <b>u/g</b> ” 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
<b>Cough</b>		
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 <b>NO</b> to questions 1 and 2, go to question 4. If <b>YES</b> 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"/>
<b>Phlegm</b>		
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 <b>NO</b> to questions 4 and 5, go to question 9. If <b>YES</b> 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 <b>NO</b> to question 7, go to question 9. If <b>YES</b> to question 7:		
8. Have you had more than one such period?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Breathlessness on activity</b>		
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 <b>NO</b> to question 9, go to question 12. If <b>YES</b> 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 <b>NO</b> to question 10, go to question 12. If <b>YES</b> 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"/>
<b>Breathlessness at rest</b>		
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
<b>Wheezing</b>		
14. Does your chest ever sound wheezy or whistling?	<input type="checkbox"/>	<input type="checkbox"/>
If <b>NO</b> to question 14, go to question 18. If <b>YES</b> 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 <b>NO</b> to question 16, go to question 18. If <b>YES</b> to question 16:		
17. Was your breathing normal between attacks?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Breathing Difficulty</b>		
18. Does your chest ever feel tight or your breathing become difficult?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Smoking History</b>		
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 <b>NO</b> to question 19, go to question 23. If <b>YES</b> 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?	_____	
<b>Past Chest Illness</b>		
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 <b>NO</b> to question 23, go to question 26. If <b>YES</b> 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"/>
<b>If yes, provide details:</b>		
.....		
.....		
.....		

**SECTION III – LUNG FUNCTION TEST**

Height _____ (cm) <small>(must be measured)</small>	Age _____ (years)	Weight _____ (kg)
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**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 <sub>1</sub>			
FVC			

Bronchodilator use: Yes  No

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

Comments (especially if any difficulty with spirometry):

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