



**MEDICAL HISTORY (Applicant to complete):**

Are you now suffering from or have you ever suffered from any of the following conditions, injuries or disabilities? (Answer either **YES** – “**Y**” or **NO** – “**N**” in the space provided - details of any **YES** responses should be written on the next page.)

3.	Heart disease		30.	Back or neck pain or injury	
4.	Palpitations, extra or skipped heart beats		31.	Tennis elbow or golfer's elbow	
5.	Blood disease		32.	Upper limb or shoulder pain	
6.	High blood pressure		33.	Any fracture	
7.	Abnormal shortness of breath, leg pain or chest pain on exertion		34.	Joint problems, pains, injuries, arthritis, dislocated joints	
8.	Lung disease (eg asthma, bronchitis, emphysema, tuberculosis)		35.	Occupational overuse syndrome (OOS) or repetitive strain injury (RSI)	
9.	Epilepsy, fainting attacks, fits, blackouts or head injury		36.	X-ray or MRI for back/neck or joint pain	
10.	Dizziness or vertigo		37.	Problem with balance or coordination	
11.	Migraine or frequent headaches		38.	Foot problems or problems with footwear	
12.	Frequent coughing/bring up phlegm		39.	Skin cancers	
13.	Coughing and/or shortness of breath due to dust, fumes or gasses.		40.	Muscle or ligament strain	
14.	Blood in urine		41.	Weakness in arms or legs.	
15.	Stomach or duodenal ulcers or frequent indigestion		42.	Varicose veins	
16.	Hernia or rupture		43.	Allergies (hay fever, sinusitis, urticaria/hives)	
17.	Liver disease (eg jaundice, hepatitis, cirrhosis)		44.	Allergies to medication or chemical substances	
18.	Kidney or bladder disease		45.	Skin diseases (eg psoriasis, dermatitis, eczema)	
19.	Sugar diabetes		46.	Abdominal pain or bowel disorder	
20.	Thyroid disease		47.	Tenosynovitis or tendonitis	
21.	Eye/vision problems (including wearing glasses or contact lenses)		48.	Back pain lasting more than two weeks	
22.	Hearing loss or deafness		49.	Any form of cancer or tumour	
23.	Night blindness or problem seeing at low levels of illumination.		50.	Any significant infectious illness or communicable disease	
24.	Sensitivity to chemicals, dust, fumes, solvents or other substances		51.	Have you ever had any operations or surgical treatment?	
25.	Nervous, mental or psychiatric condition		52.	Any abnormal blood or pathology test	
26.	Have you ever been admitted to hospital?		53.	Has your weight altered in the last 12 months?	
27.	Are you currently receiving treatment including treatment from a person who is NOT a registered medical practitioner.		54.	Have you been absent from work or full time education through illness or injury for two or more weeks at any time?	
28.	Are you are taking medication or receiving treatment . (Please include items such as eye drops, asthma "puffers", nasal sprays, creams, vitamins, physiotherapy, etc)		55.	Have you ever worked under conditions or with substances which may have been hazardous to your health? (eg toxic chemicals, noise, dusts, asbestos, radiation)	
29.	Anxiety, stress reaction or depression		56.	Any condition, complaint, ache, pain or disability not mentioned above	

Please provide details of all **YES** responses to the above questions.

Question Number	Year/s occurred	Details	Doctor's comments upon examination

Personal Details	Y/N	If <b>YES</b> provide details	Doctor's comments
57. Do you smoke or have you ever regularly smoked tobacco or other substances.		How many per day:..... From (year):..... To (year):..... Type:.....	
58. Do you undertake any regular exercise.			
59. Do you drink alcohol?		(Number of drinks per week)	
60. Have you been vaccinated against TETANUS in the last 10 years?			
61. Have you been vaccinated against HEPATITIS A in the last 10 years?			
62. Have you been vaccinated against HEPATITIS B in the last 10 years?			
63. Have you been vaccinated against TYPHOID in the last 10 years?			
64. Are you now or have you ever been dependent on or addicted to drugs or alcohol?			

Family History	Y/N	If <b>YES</b> provide details, including age of onset.	Doctor's comments
1 Has anyone in your family suffered from heart disease?			

## Section 4 (Applicant to complete in presence of doctor/nurse)

### Declaration and Medical Release Authority

**Declaration:** I, (write name) ..... hereby declare that the information provided in this document is a true and accurate record of my medical history. I understand that the Kokoda Trail is located in remote and mountainous jungle terrain in a tropical region. Much of the area is inaccessible by helicopter and remote from medical facilities. The trek itself is physically demanding and strenuous. I am not aware of any health condition, which might interfere with my ability to complete the trek, or which might lead to foreseeable injury to others or myself during the trek.

While I understand that the detailed results of this assessment will remain confidential, I give my consent for the examining doctor to release to the trekking company any medical information, which is relevant in determining my suitability for the trek, including the results of all medical tests/investigations conducted.

Applicant (signature):..... Date: ...../...../.....

Witness (signature):..... Witness Name: (print):.....

### Cardiac Risk Factors:

Diabetes	Yes/No
Hypertension	Yes/No
Smoking History	Yes/No
Hyperlipidaemia	Yes/No
Family History of Heart Disease <60	Yes/No
BMI >35	Yes/No

Age <30	ECG
Age 30-40 NO cardiac risk factors	ECG
Age 30-40 and 1 or more risk factors	Exercise Stress Test
Age >40	Exercise Stress Test

# Section 5

## EXAMINATION

### GENERAL MEASUREMENTS:

Height \_\_\_\_\_ cm Weight \_\_\_\_\_ kg

Body Mass Index (BMI): ..... Healthy / Overweight / Obese

**BLOOD PRESSURE:** \_\_\_\_\_ / \_\_\_\_\_ mmHg \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**PULSE RATE:** \_\_\_\_\_ BPM  Regular  Irregular

### URINALYSIS: (NIL, +, ++, +++, +++++)

Protein [ ] Glucose [ ] Blood [ ] Other [ ] – specify:.....

Blood glucose (if glycosuria) ..... mmol/L

### EXAMINATION (✓ = Yes or Normal x = No or Abnormal → *Comments required below\**)

<p><b>GENERAL EXAMINATION</b></p> <p>Respiratory</p> <p style="padding-left: 100px;">Lung Expansion</p> <p>Muscular/Skeletal Assessment</p> <p style="padding-left: 100px;">SLR</p> <p style="padding-left: 100px;">Spinal Movement</p> <p style="padding-left: 100px;">Upper Limbs</p> <p style="padding-left: 100px;">Lower limbs</p> <p style="padding-left: 100px;">Romberg's Test</p>	<p>✓, x</p>	<p><b>Abdominal Assessment</b></p> <p style="padding-left: 100px;">Abdomen</p> <p style="padding-left: 100px;">Hernial orifices</p> <p><b>Skin Condition</b></p> <p style="padding-left: 100px;">General Condition</p> <p style="padding-left: 100px;">Allergies/Irritations</p> <p><b>Other</b></p> <p style="padding-left: 100px;">Behaviour during examination</p> <p style="padding-left: 100px;">Other</p>	<p>✓, x</p>
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ECG Normal/Abnormal.....

Exercise Stress Test NA/Normal/Abnormal.....

### \*DOCTOR'S COMMENTS ON ANY ABNORMAL FINDINGS (*Attach sheet if space is insufficient*)

COMMENTS

**ASSESSMENT / OPINION**

In my opinion ..... date of birth.....

Of.....

.....

Is **FIT/UNFIT** to trek the Kokoda Trail

Doctor _____ Cental City Medical Centre 420 Wellington Street PERTH WA 6000 Ph 9221 4747 Fax 9221 4069	..... Signature of examining Doctor	...../...../..... Date of assessment
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