Pre-Placement Examination for the Job of Law Enforcement Officer MEDICAL HISTORY FORM

Name:

_____

Last First Middle Initial

Address: _____

City: _____ State:_____ Zip:_____

Home phone: _____ Cell phone: _____

E-mail address: _____

Date of birth: _____

Gender: ☐ Male ☐ Female

1. Work History

1.1 – Work History or jobs held since high school:

Dates	Job Title	Brief Description of Work

1.2 – Have you ever been exposed to fumes, chemicals, dusts, heavy metals, or radiation in your work or hobbies?

☐ Yes ☐ No If yes, list types of exposure: _____

_____

1.3 – Military Service:

Were you in the military? ☐ Yes ☐ No If yes, for how long? _____

Job titles _____

What was your rank on discharge? _____

Did you receive your VA disability rating? ☐ Yes ☐ No

Have you been rejected or discharge for military service for medical or psychological reasons? ☐ Yes ☐ No

If yes, please give date and reason: _____

_____

2. SOCIAL HISTORY

2.1 – Fitness history

List Hobbies:_____

_____

List Sports and Recreational Activities in which you participate:_____

_____

How many times a week do you engage in a physical activity vigorous enough to work up a sweat? _____

2.2 – Smoking

Do you currently use tobacco products? ☐ Yes ☐ No

Have you ever used tobacco products in the past? ☐ Yes ☐ No

How many packs a day do you currently or did you previously smoke? _____

When did you start smoking? _____

When did you quit smoking? (if applicable) _____

2.3 – Alcohol

Do you drink alcohol beverages? ☐ Yes ☐ No

Amount per week: _____

2.4 – Caffeinated Drinks

Do you drink caffeinated beverages? ☐ Yes ☐ No

Amount per day: _____

2.5 – Drugs

Have you ever used any controlled substance not prescribed by a physician? ☐ Yes ☐ No

If yes, please specify the controlled substance(s): _____

2.6 – Disability

Have you ever applied for disability? ☐ Yes ☐ No

Have you ever received workers' compensation benefits? ☐ Yes ☐ No

Have you ever received compensation or settlement for an injury or any medical condition? ☐ Yes ☐ No

Have you ever been denied life or health insurance or offered it only at additional rates? ☐ Yes ☐ No

Have you ever been disqualified or discharged from the armed forces for medical reasons? ☐ Yes ☐ No

Have you ever had to change jobs for medical reasons? ☐ Yes ☐ No

Are you currently disabled? ☐ Yes ☐ No

How many workdays did you miss in the past 2 years for medical reasons? ☐ Yes ☐ No

Have you ever been out of work because of injury, illness, or other medical reason for more than 3 days? ☐ Yes ☐ No

Have you ever had your job modified because of injury, illness, or other medical reason? ☐ Yes ☐ No

If you answered yes to any of these questions, please explain: _____

_____

_____

Do you need any accommodation in order to perform the essential job functions of law enforcement officer with_____ [Agency name]? ❑ Yes ❑ No

If yes, please explain: _____

_____

_____

3. HEALTH HISTORY

3.1 – Medications

Have you been prescribed any medication within the past 5 years? If none, check "NONE."

❑ NONE

If yes, please explain (name of medication, dose, date when started, duration of treatment, reason for treatment):

_____

_____

_____

_____

_____

_____

_____

Are you taking any medication (prescription and non-prescription) on a regular basis (more than 3 times a week)? If none, check "NONE."

❑ NONE

If yes, please explain (name of medication, dose, date when started, duration of treatment, reason for treatment):

_____

_____

_____

_____

_____

_____

_____

Supplements and vitamins – Have you been taking any supplement or vitamin on a regular basis (more than once a week) within the past 5 years? If none, check "NONE."

❑ NONE

If yes, please explain:

_____

_____

_____

_____

_____

3.2 – Surgeries

Have you ever had, or been advised to have, surgery (including outpatient procedure)? ☐ Yes ☐ No

If yes, please explain (type of surgery, date, reason for surgery, name of hospital)

_____

_____

_____

_____

3.3 – Hospitalizations

Have you ever been hospitalized? ☐ Yes ☐ No

If yes, please explain (reason for hospitalization, diagnosis, date, name of hospital)

_____

_____

_____

_____

3.4 – Emergency Department Visits

Have you been to an emergency department in the past 10 years? ☐ Yes ☐ No

If yes, please explain (reason for visit, diagnosis, date, name of hospital)

_____

_____

_____

_____

3.5 – General Issues

Are you currently treated for any medical condition? ☐ Yes ☐ No

If yes, please explain: _____

_____

Are you currently treated for any mental health condition? ☐ Yes ☐ No

If yes, please explain: _____

_____

Are you currently under the care of health care professionals? ☐ Yes ☐ No

If yes, please write their name, specialties and phone numbers:

_____

_____

_____

_____

Have you received any medical treatment or therapy or visited a doctor, physician, health care provider or alternative medicine provider during the past 5 years? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

3.6 – Organ Systems

Females only: Are you pregnant? ☐ Yes ☐ No

Have you ever had or have you now any of the following?

General Condition

		Yes	No	If yes, provide details with date of onset and date of recovery
1	Recent gain or loss of weight			
2	Cancer			
3	Diabetes			
4	High blood sugar			
5	Tuberculosis			
6	Thyroid disease			
7	Positive tuberculin skin test			
8	Low blood sugar			
9	Adrenal gland disease			
10	Mumps			
11	Measles			
12	Poliomyelitis			
13	Hyponatremia (low sodium) with exertion			
14	Parathyroid gland disease			
15	Pituitary gland disease			
16	Heat stroke			
17	Heat exhaustion			
18	High cholesterol			
19	High triglycerides			

Head, ears, nose, throat – *Have you ever had or have you now any of the following?*

20	Wear a hearing aid in left ear			
21	Wear a hearing aid in right ear			
22	Frequent nosebleeds			
23	Bleeding gums			
24	Chronic sinus condition			
25	Hoarseness			
26	Persistent sore throat			
27	Loss of taste			
28	Loss of smell			
29	Trouble smelling odors			
30	Hearing difficulties			
31	Ringing in ears			
32	Perforated eardrum			
33	Persistent ear infection			
34	Seasonal allergies			
35	Dental condition other than cavities			
36	Cochlear implant			
37	Meniere's disease			

Eyes – *Have you ever had or have you now any of the following?*

38	Eye surgery (PRK, LASIK or other)			
39	Eyeglasses			
40	Contact lenses			
41	Glaucoma			
42	Cataract			
43	Frequent eye irritation			

44	Color blindness			
45	Double vision			
46	Eye injury			
47	Blindness			
48	Retinal detachment			
49	Optic neuritis			
50	Retinopathy			

Heart and blood vessels – *Have you ever had or have you now any of the following?*

51	Heart attack			
52	Coronary artery disease			
53	Angina			
54	Stent in coronary artery			
55	Atrial fibrillation			
56	Supraventricular tachycardia			
57	Heart arrhythmia (heart beating irregularly)			
58	Palpitations			
59	Cardiomyopathy			
60	Congestive heart failure			
61	Cardiac surgery			
62	Wolff-Parkinson-White syndrome			
63	Chest pain			
64	Shortness of breath			
65	Swelling of legs or feet			
66	Heart murmur			
67	Rheumatic fever			
68	Pulmonary hypertension			
69	Pulmonary embolus			
70	Deep venous thrombosis (blood clot)			
71	Syncope (passing out)			
72	Cardiac arrest			
73	Abnormal electrocardiogram (EKG)			
74	Hypertension			
75	Chest pressure			
76	High or low blood pressure			
77	Raynaud's syndrome			
78	Pacemaker			
79	Implantable defibrillator			
80	Abnormal heart valve			
81	Heart skipping or missing a beat			
82	Heartburn or indigestion that is not related to eating			
83	Any other heart problem that you have been told about			
84	Any other symptoms that you think may be related to heart or circulation problems			

Lungs – *Have you ever had or have you now any of the following?*

85	Pneumonia			
86	Chronic bronchitis			
87	Asthma or inhaler use			
88	Emphysema			
89	COPD			

90	Coughing blood			
91	Broken ribs			
92	Wheezing			
93	Cystic fibrosis			
94	Silicosis			
95	Dust disease			
96	Asbestosis			
97	Pneumothorax (collapsed lung)			
98	Lung cancer			
99	Valley fever			
100	Any chest injuries or surgeries			
101	Any lung problem that you have been told about			

Gastrointestinal – *Have you ever had or have you now any of the following?*

102	Abdominal trouble			
103	Abdominal pain			
104	Inflammatory bowel disease			
105	Colitis			
106	Crohn's disease			
107	Pancreatitis			
108	Ulcer			
109	Persistent nausea			
110	Persistent indigestion			
111	Acid reflux			
112	Vomiting blood			
113	Blood in stool			
114	Liver cirrhosis			
115	Hepatitis			
116	Gallstones			
117	Jaundice			
118	Loss of appetite			
119	Hernia			
120	Irritable bowel syndrome			
121	Gallbladder disease			

Genitourinary – *Have you ever had or have you now any of the following?*

122	Kidney stone			
123	Kidney infection			
124	Blood in urine			
125	Prostate condition			
126	Endometriosis			
127	Polycystic kidney disease			
128	Kidney disease			

Blood disorders – *Have you ever had or have you now any of the following?*

129	Sickle cell disease			
130	Sickle cell trait			
131	Anemia			
132	Blood transfusion			
133	Low platelet count			
134	Bleeding disorder			
135	Hemophilia			
136	Von Willebrand disease			

Nervous system – *Have you ever had or have you now any of the following?*

137	Seizure			
138	Epilepsy			
139	Stroke			
140	Migraine			
141	Headaches			
142	Vertigo or motion sickness			
143	Dizziness			
144	Memory troubles			
145	Tremors			
146	Parkinson's disease			
147	Paralysis			
148	Numbness or tingling			
149	Weakness of body part			
150	Dyslexia			
151	Speech problem			
152	Stuttering			
153	Meningitis			
154	Encephalitis			
155	Concussion			
156	Traumatic brain injury			
157	Bleeding inside the skull			
158	Abnormal balance			
159	Abnormal coordination			
160	Multiple sclerosis			
161	Myasthenia gravis			
162	Aneurysm			

Musculoskeletal – *Have you ever had or have you now any of the following?*

163	Broken bone			
164	Dislocation			
165	Spine surgery			
166	Arthritis			
167	Bursitis			
168	Tendonitis			
169	Back pain			
170	Ankylosing spondylitis			
171	Cumulative trauma disorder			
172	Neck pain or injury			
173	Back injury			
174	Sciatica			
175	Shoulder problem			
176	Wrist/hand/elbow problem			
177	Carpal tunnel syndrome			
178	Knee problem			
179	Ankle/foot problem			
180	Hip problem			
181	Chiropractic treatment			
182	Gout			
183	Osteoporosis			
184	Rhabdomyolysis			
185	Amputation			
186	Fibromyalgia			
187	Scoliosis			

188	Systemic lupus erythematosus			
189	Dermatomyositis			
190	Scleroderma			
191	Problems gripping, lifting, or reaching			
192	Problems with kneeling or squatting			

Skin – *Have you ever had or have you now any of the following?*

193	Abscess			
194	Frequent bruising			
195	MRSA infection of the skin			
196	Frostbite			
197	Eczema or hives			
198	Psoriasis			

Sleep issues – *Have you ever had or have you now any of the following?*

199	Sleep apnea			
200	Narcolepsy			
201	Shift work disorder			
202	Insomnia			
203	Any other sleep disorder			
204	Difficulty falling asleep			
205	Waking up during the night			
206	Trouble staying awake during the day			
207	Have you been told that you snore?			
208	Have you often tired during the day?			
209	Do you know if you stop breathing while you are asleep?			
210	Has anyone witnessed you stop breathing while you are asleep?			
211	Are you tired after sleeping?			
212	Are you tired during wake time?			
213	Have you ever fallen asleep while driving?			

Mental health – *Have you ever had or have you now any of the following?*

214	Depression			
215	Difficulty concentrating			
216	Suicide attempt			
217	Thoughts of suicide			
218	Treatment by psychiatrist			
219	Treatment by psychologist			
220	Counseling			
221	Hospitalization for mental problem			
222	Anxiety			
223	Psychosis			
224	Bipolar disease			
225	Schizophrenia			
226	Hallucinations			
227	Use of recreational drugs			
228	Alcohol abuse			
229	Alcoholism			
230	Addiction			
231	Attention deficit disorder			
232	Post-traumatic stress disorder			

233	Feeling stressed most of the time			
234	Panic attacks			
235	Claustrophobia			
236	Fear of heights			
237	Amnesia			
238	Learning disability			
239	Have you ever felt you should cut down on your drinking?			
240	Have people annoyed you by criticizing your drinking?			
241	Have you ever felt bad or guilty about your drinking?			
242	Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye opener)?			
243	During the past month, have you often been bothered by feeling down, depressed or hopeless?			
244	During the past month, have you often been bothered by little interest or pleasure in doing things?			

Allergies – *Have you ever had or have you now any of the following?*

245	Do you have any allergy?			
246	Seasonal allergies			
247	Anaphylaxis (severe allergy)			
248	Allergic reactions that interfere with your breathing			
249	Allergy to medications			
250	Allergy to food			
251	Allergy to cayenne or chili peppers			
252	Allergy to latex			
253	Allergy to metals			
254	Allergy to bee stings			
255	Allergy to plant (e.g., poison ivy)			
256	Allergy to cats			
257	Allergy to dogs			
258	Allergy to fumes			
259	Allergy to dust			
260	Has a medical professional suggested that you carry an Epi-Pen?			
261	Other allergies (please list)			

Do you use any medical appliances or implanted medical devices not previously mentioned?

☐ Yes ☐ No

If yes, please explain:

_____

_____

_____

_____

_____

Do you *CURRENTLY* have any of the following symptoms of pulmonary or lung illness?

		Yes	No	If yes, provide details with date of onset and date of recovery
262	Shortness of breath			
263	Shortness of breath when walking fast on level ground or walking up a slight hill or incline			
264	Shortness of breath when walking with other people at an ordinary pace on level ground			
265	Have to stop for breath when walking at your own pace on level ground			
266	Shortness of breath when washing or dressing yourself			
267	Shortness of breath that interferes with your job			
268	Coughing that produces phlegm (thick sputum)			
269	Coughing that wakes you early in the morning			
270	Coughing that occurs mostly when you are lying down			
271	Coughing up blood in the last month			
272	Wheezing			
273	Wheezing that interferes with your job			
274	Chest pain when you breathe deeply			
275	Any other symptoms that you think may be related to lung problems			

Have you ever used a respirator? ☐ Yes ☐ No

If you have used a respirator, have you ever had any of the following problems?

- Eye irritation ☐ Yes ☐ No
- Skin allergies or rashes ☐ Yes ☐ No
- Anxiety that occurs only when you use the respirator ☐ Yes ☐ No
- Unusual weakness or fatigue ☐ Yes ☐ No
- Any other problem that interferes with your use of a respirator ☐ Yes ☐ No

Provide details where necessary. Do not leave any question blank. Do not use “white out” or correction tape. Additional information must be documented on the attached “Supplemental Information” sheet.

Supplemental Information

Additional space for further explanation and information relating to medical history:

CERTIFICATION

Read the following carefully before signing this certification. A false answer to any question in this statement may be grounds for disqualification and may be punishable by fine or imprisonment. Failure to disclose a disease, condition, medication, or any other information that affects or could affect your ability to perform the essential job functions or that could endanger others is grounds for immediate termination and is possibly a crime.

I have completed this statement with the knowledge and understanding that any or all items contained herein may be subject to investigation and I consent to the release of information concerning my capacity and fitness by employers, educational institutions, law enforcement agencies, and other individuals and agencies, to duly accredited investigators, and other authorized employees of _____ [name of Agency] for that purpose.

My signature below attests that all information that I have reported is true and correct to the best of my knowledge, and that I have not knowingly omitted to report any material information relevant to this form.

I authorize physicians designated by _____ [name of Agency] to perform a medical examination and necessary medical tests for to determine if I am medically able to perform the essential job functions of law enforcement officer. I understand that this information will be treated as a confidential medical record by _____ [name of Agency] in accordance with state and federal law.

SIGNATURE _____ DATE _____

PRINT NAME _____ (applicant)

Medical Provider Review

I certify that I reviewed the Medical History Form provided by _____ [name of Applicant], discussed responses and appended the form as appropriate.

_____ _____

Medical provider signature Date

_____

Medical provider name