

# MEDICAL HISTORY STATEMENT – Training Candidate

## Instructions:

- Fill out the questionnaire completely and accurately. Keep in mind that all statements are subject to verification; deliberate inaccuracies or incomplete statements may bar or remove you from training. A “yes” answer does not necessarily mean that you will be disqualified.
- This form must be completed and presented annually to the Association Training Division.
- This medical history statement is confidential.
- Type or legibly print (in ink).

## SECTION 1: CANDIDATE IDENTIFICATION

1. CANDIDATE'S NAME (Last, First, Middle)		2. SOCIAL SECURITY NUMBER Last 4 digits:	3. BIRTHDATE (MM/DD/YYYY)
4. ADDRESS WHERE YOU CAN BE CONTACTED (Street / P.O. Box)		5. CITY	6. STATE / ZIP
7. PHONE NUMBERS WHERE YOU CAN BE REACHED Home/Office: ( ) -      Mobile: ( ) -		8. E-MAIL	

## SECTION 2: JOB HISTORY AND PHYSICAL ACTIVITY

9. List current and all previous jobs held in the last 5 years, including military service.

JOB TITLE	PRIMARY DUTIES	EMPLOYER	APPROXIMATE DATES
A)			From: To:
B)			From: To:
C)			From: To:
D)			From: To:
E)			From: To:
F)			From: To:
G)			From: To:
H)			From: To:
I)			From: To:

10. Describe your typical physical activity, including that at work. Indicate how often and how long you've been doing it.

	EXERCISE / ACTIVITY	HRS PER WK	HOW LONG?
A)			yrs    mos
B)			yrs    mos
C)			yrs    mos

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## SECTION 3: MEDICAL HISTORY

Y N ? Answer each of the following questions.

11. Have you ever failed to complete a peace officer academy training program?
12. Have you ever been refused employment or been unable to hold a job because of any physical, psychological, or other medically-related reason?
13. Have you ever worked as a peace officer before?
14. Have you ever coughed, or wheezed, or had chest discomfort during or after exercise?
15. Do you have any physical limitations?
16. Have you been rejected for, or discharged from the military because of, physical, mental, or other medically-related reasons?
17. Do you need any reasonable accommodation to assist you in performing required job tasks?
18. Have you ever been absent from work due to job stress?
19. Have you missed more than five days from work in the past 12 months due to medically-related reasons?
20. Have you ever been absent from work because of back/neck pain or problems?
21. Have you ever seen a doctor for back/neck pain or problems?
22. Do you currently have a cold or cough, or have you had either in the past two weeks?
23. In the past year, have you had a change in the size and color of a mole or a sore that would not heal?
24. Do you ever wake up short of breath?
25. Have you ever had any breathing problems using a gas mask? (Check "No" if you have never used a gas mask.)
26. Do you currently smoke cigarettes? IF YES: How many packs per day?      For how long (in years)?
27. Are you an ex-smoker? IF YES: How many years did you smoke?      Packs per day?      Approximate date quit
28. Have you used chewing tobacco or smoked cigars/pipes in the last 15 years?
29. Have you ever had a positive drug or alcohol test?
30. Are you now or have you ever been enrolled in a drug or alcohol rehabilitation program?
31. Per week, I drink:    \_\_ bottles/cans of beer      \_\_ glasses of wine      \_\_ glasses of hard liquor
32. Has anyone ever been concerned about your drinking or suggested that you cut down?
33. Have you ever been convicted of driving under the influence (DUI)?
34. Have you ever felt bad about your drinking?
35. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?
36. I am:     Right-handed     Left-handed
37. Have you ever been hospitalized overnight (except for pregnancy)?
38. Have you had any surgical operations?
39. Have you been exposed to loud noise today? IF YES: Were you wearing hearing protection?
40. Have you sustained any disabling illnesses or medical conditions within the past 5 years?
41. Do you occasionally use, or are you currently taking, any prescription or over-the-counter medications?
42. Have you taken any medication within the past 12 months for any reason?

*continues*



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## SECTION 4: MEDICAL CONDITIONS – Indicate if you have, or ever had, any of the following conditions. If you're unsure, mark "?"

	Y	N	?		Y	N	?		Y	N	?
<b>44. EYE, EAR, NOSE, THROAT</b>											
A) Eye surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	H) Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	O) Ringing or buzzing in ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B) Refractive surgery (e.g., Lasik, PRK)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I) Blurred or double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P) Decreased hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C) Orthokeratology / retainer lenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	J) Abnormal color vision test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Q) Ear surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D) Vision therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	K) Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	R) Earache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E) Vision impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L) Loss of smell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	S) Abnormal audiogram	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F) Need to wear corrective lenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	M) Allergy / Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
G) Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N) Ruptured ear drum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<b>45. RESPIRATORY</b>											
A) Asthma (age at last episode: ____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D) Positive TB skin test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G) Chest tightness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B) Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E) Coughed up blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	H) Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C) Chronic or frequent cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F) Pneumothorax (collapsed lung)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I) Blood clot in lung	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>46. GASTROINTESTINAL</b>											
A) Ulcer / Stomach trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F) Gall bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	K) Abnormal liver test / Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B) Vomited blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G) Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L) Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C) Persistent diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	H) Mucous in stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	M) Irritable Bowel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D) Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I) Black / bloody bowel movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N) Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E) Recurrent hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	J) Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<b>47. GENITOURINARY</b>											
A) Kidney disease or stone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D) Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G) Menstrual discomfort that kept you from work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B) Bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E) Prostatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	H) Currently pregnant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C) Difficulty urinating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F) Irregular vaginal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<b>48. CARDIOVASCULAR</b>											
A) Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E) Enlarged heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I) Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B) Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F) Palpitation (irregular heartbeat)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	J) Swelling of foot or leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C) Heart failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G) High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	K) Painful varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D) Heart valve abnormality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	H) Pain or discomfort in chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<b>49. MUSCULOSKELETAL</b>											
A) Fracture / Broken bone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	C) Neck trouble / pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E) Arthroscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B) Back trouble / pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D) Shin pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F) Arthritis / Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>50. JOINT INJURY / SURGERY / DISLOCATION / PAIN / SWELLING</b>											
A) Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D) Fingers / Toes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G) Ankle / Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B) Elbow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E) Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	H) Other joint pain or swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C) Wrist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F) Knee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				



