

MEDICAL HISTORY QUESTIONNAIRE

This Box To Be Completed By The Employing Agency:

Name: _____ <div style="display: flex; justify-content: space-around; font-size: small;"> Last First Middle </div> Address: _____	You are to report to: _____ Address: _____ At _____ o'clock _____ Mo. Day Yr. with this questionnaire completed.
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TO THE APPLICANT:

A Medical Examination is required by the Commission on Law Enforcement Standards & Training. Your cooperation in filling in this questionnaire as completely as possible will expedite the evaluation and avoid delay.

Type of Exam: **Baseline** Periodic Exam Exit

Instructions to Applicants:	Complete this form prior to your physical examination and give the original to the employing agency and a copy to the examining physician and psychological examiner at the time of examination. Answer all questions completely and accurately.		
Applicant's Name (Last, First, Middle)		Address	
Date of Birth	Age	Current Occupation	
SECTION A	HAVE YOU EVER OR DO YOU NOW HAVE ANY OF THE FOLLOWING? FOR "YES" ANSWERS, SUPPLY FULL DETAILS IN SECTION B ON THE REVERSE SIDE. IF THE CONDITION REQUIRED HOSPITALIZATION, CHECK THE CORRESPONDING BOX.		

GENERAL:	YES	NO	HOSP	HEART:	YES	NO	HOSP	MUSCULAR / SKELETAL:	YES	NO	HOSP
UNEXPLAINED WEIGHT LOSS/GAIN				HEART ATTACK				MUSCLE WEAKNESS			
EXCESSIVE/UNEXPLAINED FATIGUE				ABNORMAL HEART RHYTHM				AMPUTATION/MISSING DIGITS			
APPLIED FOR DISABILITY				CARDIAC STENT OR ANGIOPLASTY				MODERATE/SEVERE JOINT PAIN			
HEAT-RELATED ILLNESS				HEART SURGERY OR ABLATION				LOSS OF USE OF ARM/LEG			
ALLERGY AFFECTING BREATHING				HIGH BLOOD PRESSURE				SURGERY OF JOINT OR EXTREMITY			
CANCER				PALPITATIONS				CHRONIC BACK PAIN			
IMMUNOLOGIC DISORDER				CONGENITAL HEART DISEASE				MODERATE/SEVERE ARTHRITIS			
BRAIN/ NERVES:				ATRIAL FIBRILLATION OR SVT				HERNIATED DISC OR SCIATICA			
CONCUSSION OR BRAIN INJURY				PACEMAKER				SCOLIOSIS/OTHER SPINE DISORDER			
FREQUENT HEADACHES				IMPLANTED DEFIBRILLATOR				ANY OTHER ILLNESS OR CONDITION			
MIGRAINE HEADACHES				OTHER HEART PROBLEM OR DISEASE				KIDNEYS:			
HEAD/CRANIAL SURGERY				LUNGS:				PROTEIN/BLOOD/SUGAR IN URINE			
BRAIN TUMOR				ASTHMA OR WHEEZING				KIDNEY DISEASE			
STROKE/TIA				EMPHYSEMA OR COPD				KIDNEY STONES			
MEMORY LOSS				POSITIVE TEST FOR TUBERCULOSIS				SKIN:			
SEIZURES (CURRENT OR PREVIOUS)				SHORTNESS OF BREATH				CHRONIC SKIN RASH OR DISEASE			
NUMBNESS OR TINGLING				COUGH LASTING MORE THAN 2 MONTHS				CHANGE IN MOLES			
TREMORS				USE OF INHALERS				CONDITION AFFECTING SWEATING			
NARCOLEPSY				ACUTE OR CHRONIC LUNG INFECTION				PSYCHIATRIC:			
FAINTING OR UNCONSCIOUSNESS				COLLAPSED LUNG				DEPRESSION, ANXIETY, BIPOLAR			
BALANCE/COORDINATION PROBLEM				PULMONARY EMBOLUS				OTHER MENTAL HEALTH DISORDER			
HEAD, EYES, EARS, NOSE, THROAT:				HISTORY OF TUBERCULOSIS				INSOMNIA, OTHER SLEEP DISORDER			
DIZZINESS OR VERTIGO				SLEEP APNEA				ALCOHOL DEPENDENCE			
COLOR VISION PROBLEMS				OTHER LUNG DISEASE OR SURGERY				SUBSTANCE USE DISORDER			
EYE DISEASE, INJURY, OR SURGERY				ENDOCRINE:				SURGICAL:			
CONTACT LENSES/GLASSES				DIABETES				ORGAN TRANSPLANT			
HEARING AIDS/COCHLEAR IMPLANT				THYROID DISORDER				PROSTHETIC DEVICE			
EAR DISEASE OR INJURY				OTHER ENDOCRINE DISORDERS				IMPLANTED PUMP (EX: INSULIN)			
DIFFICULTY HEARING/HEARING LOSS				GASTROINTESTINAL:				IMPLANTED ELECTRICAL DEVICE			
VASCULAR / BLOOD:				LIVER DISEASE OR HEPATITIS				CONGENITAL ANOMALIES/DEFECTS			
HISTORY OF BLOOD CLOTS				HERNIAS				NECK OR SPINE SURGERY			
ANEMIA/SICKLE CELL/OTHER BLOOD DISORDERS				ABDOMINAL SURGERY				SURGERIES OR HOSPITALIZATIONS			
VARICOSE VEINS				IRRITABLE BOWEL SYNDROME				OTHER (EXPLAIN)			
ANEURYSM (BRAIN, AORTA, ETC.)				RECTAL BLEEDING							
USE OF BLOOD THINNERS				GASTRITIS OR ULCERS							
UNUSUAL BLEEDING/BRUISING				OTHER GASTROINTESTINAL DISORDER							

SECTION A CONTINUED		NO	YES
HAVE YOU HAD ANY OTHER ILLNESS, INJURY, OR PHYSICAL CONDITION NOT NAMED ABOVE, OTHER THAN CHILDHOOD DISEASES OR MINOR ILLNESSES? IF "YES", EXPLAIN IN SECTION B BELOW.			
HAVE YOU HAD AN INJURY WITHIN THE LAST 5 YEARS WHICH CAUSED YOU TO LOSE TIME FROM WORK?			
HAVE YOU EVER BEEN DENIED EMPLOYMENT OR INSURANCE FOR MEDICAL REASONS?			
HAVE YOU EVER BEEN DEFERRED FROM MILITARY SERVICE FOR MEDICAL, EMOTIONAL, OR HEALTH REASONS?			
HAVE YOU EVER BEEN DISCHARGED OR RELEASED FROM EMPLOYMENT OR FROM THE ARMED FORCES FOR MEDICAL, EMOTIONAL, OR HEALTH REASONS?			
HAVE YOU EVER RECEIVED OR APPLIED FOR PENSION OR COMPENSATION FOR DISABILITY OR INJURY?			
ARE YOU PRESENTLY UNDER THE DOCTOR'S CARE FOR ANY CONDITION?			
HAVE YOU TAKEN MEDICATION WITHIN THE LAST 12 MONTHS FOR ANY REASON? IF YES, EXPLAIN IN SECTION B BELOW			
HAVE YOU EVER USED AN ILLEGAL DRUG OR USED ANY CONTROLLED SUBSTANCE WITHOUT A PRESCRIPTION? (IF "YES", EXPLAIN WHEN AND DURATION OF USE IN SECTION B BELOW)			
DO YOU HAVE ANY PHYSICAL OR EMOTIONAL LIMITATIONS THAT INTERFERE WITH YOUR DAILY ACTIVITIES? IF "YES", EXPLAIN IN SECTION B BELOW.			

PERSONAL HISTORY:	YES	NO	
HAVE YOU EVER SMOKED:			
DO YOU SMOKE NOW:			
AGE STARTED:			
TYPE SMOKED:			CIGARETTES
			PIPE
			CIGAR
HAVE YOU STOPPED SMOKING?			
AGE WHEN STOPPED?			
HOW MANY PACKS PER DAY DO/DID YOU SMOKE?			
HOW MANY PACKS PER DAY DO OR DID YOU SMOKE?			

PHYSICAL ACTIVITY/EXERCISE: (TYPE/DURATION/FREQUENCY)

	YES	NO	
DO YOU CURRENTLY DRINK ALCOHOLIC BEVERAGES:			
IF YES, AVERAGE NUMBER OF ALCOHOLIC BEVERAGES PER WEEK:	BEER	WINE	DRINKS

ALLERGIES:

MEDICATIONS: (INCLUDING PRESCRIPTIONS, OVER THE COUNTER, SUPPLEMENTS)

SECTION B	WRITE YOUR OWN ACCOUNT AND EXPLAIN ALL ITEMS ANSWERED "YES" IN THIS QUESTIONNAIRE. IDENTIFY ITEM, INCLUDE DIAGNOSIS, DATE OF ONSET, AND YOUR PRESENT CONDITION. CONTINUE ON 8 1/2 X 11 SHEETS OF PAPER AND ATTACH
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PENALTY	
ANY FALSIFICATION, WITHHOLDING OR FAILURE TO ANSWER ALL QUESTIONS COMPLETELY AND ACCURATELY MAY CAUSE FORFEITURE OF ALL RIGHTS TO THIS EMPLOYMENT.	
CERTIFICATION	
I HEREBY CERTIFY THAT THERE ARE NO WILLFUL MISREPRESENTATIONS, OMISSIONS OR FALSIFICATIONS IN THE FOREGOING STATEMENTS AND ANSWERS TO QUESTIONS, AND THAT ALL STATEMENTS AND ANSWERS ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.	
SIGNATURE OF APPLICANT	DATE SIGNED
X	

MEDICAL EXAMINATION REPORT									
To Be Completed by a Licensed Physician									
INSTRUCTIONS TO EXAMINING PHYSICIAN: Please review Health Questionnaire before examining the candidate. Do not forward this report until lab results are received. Use Section 24 for explanation of details, if necessary.									
Name (Last, First, Middle)					Date of Birth (YYYY, MM, DD)				
Height (without shoes)				Weight (without shoes and coat)				BMI	
BLOOD PRESSURE				REPEAT BLOOD PRESSURE					
PULSE RATE				REGULAR				IRREGULAR	
								RESPIRATIONS	
VISUAL ACUITY (IF APPLICANT WEARS CORRECTIVE LENSES, TEST AND RECORD WITH AND WITHOUT CORRECTIVE LENSES)									
COLOR DISCRIMINATION						DEPTH PERCEPTION			
PERIPHERAL VISION (TEMPORAL) (EACH EYE ON ZERO LINE)				RIGHT EYE		DEGREES		LEFT EYE	
								DEGREES	
						RIGHT EYE		LEFT EYE	
								BOTH	
VISUAL ACUITY				16 INCHES UNCORRECTED					
VISUAL ACUITY				16 INCHES CORRECTED					
VISUAL ACUITY				20 FEET UNCORRECTED					
VISUAL ACUITY				20 FEET CORRECTED					
EYE FUNDUS - FINDINGS									
DOES EXAM REVEAL ANY INTERNAL OR EXTERNAL EYE PATHOLOGY?								YES	NO
IF YES, DESCRIBE:									
IS THERE ANY APPARENT EYE DEVIATION?								YES	NO
NOTE ANY EYE OR VISUAL ABNORMALITY:									
HEARING (Whispered conversation at 15 ft. considered normal)									
Right 15/				HEARING AID USED		DRUM PERFORATION OR DRAINAGE			
Left 15/				NO YES		NO YES			

Physical Exam									
NL	AB	Check each item in appropriate column if examined:				Remarks:			
		Head, face							
		Eyes: PERRLA							
		EOMS							
		Funduscopic							
		Ears: External and canal							
		Tympanic membrane							
		Nose							
		Mouth, oral mucosa, palate							
		Throat							
		Skin (document scars)							
		Neck							
		Thyroid							
		Heart: Rhythm							
		Auscultation							
		Vascular (bruits, varicosities, cyanosis)							
		Lungs							
		Abdomen							
		Hernia: Umbilical							
		Inguinal (males only)							
		Musculoskeletal: (strength, ROM, deformities, scars)							
		Shoulders							
		Elbows							
		Wrists/hands							
		Hips/thighs							
		Knees							
		Ankles/feet							
		Cervical spine							
		Thoracic spine							
		Lumbar spine							
		Neuro							
		Romberg							
		BICEPS reflexes: L +/4 R +/4							
		PATELLAR reflexes: L +/4 R +/4							
		ACHILLES reflexes: L +/4 R +/4							
		Special Test:							

IMMUNIZATIONS									
HEPATITIS B STATUS	NEEDS VACCINE		VACCINATED		SEROLOGY DONE (RESULT)				
TB TESTING	TST		IGRA		DATE	RESULT			
TETANUS-DIPHThERIA	LAST DOSE DATE								
OTHER									
MEASLES/RUBEOLA									
MMPS									
RUBELLA									
POLIO									
VARICELLA									
COVID-19									

Law Enforcement Officer Examination Check Off List						
PHYSICAL EXAM	NL		AB			
VISION TESTING	NL		AB			
AUDIOGRAM	NL		AB		N/A	
SPRIOMETRY	NL		AB		N/A	
EKG	NL		AB		N/A	
LAB TESTS	NL		AB		N/A	
CHEST X-RAY	NL		AB		N/A	
URINALYSIS	NL		AB		N/A	
HEMOCCULT FIT	NL		AB		N/A	
RESPIRATOR CLEARANCE	NL		AB		N/A	
SLEEP APNEA QUESTIONNAIRE	NL		AB		N/A	
EXERCISE TOLERANCE TESTING	NL		AB		N/A	
SEROLOGY (VDRL)	NL		AB		N/A	
OTHER	NL		AB		N/A	

SEROLOGY (VDRL)	POSITIVE	NEGATIVE	NON-REACTIVE	BLOOD TYPE _____
ARE THERE ANY CONDITIONS, PHYSICAL, MENTAL OR EMOTIONAL WHICH IN YOUR OPINION, SUGGESTS FURTHER EXAMINATION?			DO YOU HAVE ANY RESERVATIONS ABOUT THIS CANDIDATE'S ABILITY TO PHYSICALLY PERFORM THE DUTIES OF A PEACE OFFICER? SEE EXAMPLES ON PAGE 5	
NO YES (Explain below)			NO YES (Explain below)	
SUMMARY/COMMENTS				
SPECIAL INSTRUCTIONS				
PHYSICIAN'S SIGNATURE			NAME AND ADDRESS OF PHYSICIAN (Print or Type)	
DATE				
CHIEF, SHERIFF, DIRECTOR, OR AUTHORIZED DESIGNEE SIGNATURE				DATE

Examples of physical duties of a peace officer can include but are not limited to:

- Standing, walking, and/or running on concrete, asphalt, or uneven unpaved surfaces;
- Sitting in a vehicle or in an office chair for an extended period of time;
- Carrying objects of varying sizes, shapes, and weights up to and sometimes in excess of 100 pounds;
- Routine lifting of objects such as a firearm or baton, lifting may include persons in custody and/or unconscious with or without assistance;
- Bending from the waist to pick up or lay down objects, may be down on knees for short periods of time as duties require;
- May be required to climb on or over various building surfaces, fences, walls, and stairs;
- Running may be required for short to long distances to escape from or reach an incident scene or in the process of arresting a suspect;

Examples of physical duties the peace officer may encounter during training include:

- Baton and Handcuffing techniques
- Weapon retention and disarming
- Basic punches and kicks
- Front, side, and lateral take down maneuvers.
- Joint locks
- Physical exercise to include obstacle courses, sit-ups, push-ups, pull-ups, weight training, and running.

*This list is not an exhaustive list of the physical duties that may be required of a peace officer. It is intended to serve as a guide for physicians in determining whether or not to state on the F-2 form that they do or do not have any reservations about a candidate's ability to physically perform the duties of a peace officer.