COMMISSION ON LAW ENFORCEMENT STANDARDS AND TRAINING FORM F-2

MEDICAL HISTORY QUESTIONNAIRE

This Box To Be Completed By The Employing Agency:

Name: _____
Last First Middle

Address: _____

You are to report to: _____

Address: _____

At _____ o'clock _____
Mo. Day Yr.
with this questionnaire completed.

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 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:**				PROTIEN/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:**				IMPLATED ELECTRICAL DEVICE	☐	☐	☐
VASCULAR / BLOOD:				LIVER DISEASE OR HEPATITIS	☐	☐	☐	CONGENITAL ANOMALIESE/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 ACTIVITES?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?			

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

ALLERGIES:

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

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 81/2 X 11 SHEETS OF PAPER AND ATTACH

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 INCHES UNCORRECTED			
VISUAL ACUITY	20 INCHES 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/_____ Left 15/_____	HEARING AID USED ☐ NO ☐ YES	DRUM PERFORATION OR DRAINAGE ☐ NO ☐ YES

Physical Exam

NL	AB	Check each item in appropriate column if examined:	Remarks:
☐	☐	Head, face	
☐	☐	Eyes: PERRLA	
☐	☐	EOM'S	
☐	☐	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?
☐ 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