MEDICAL HISTORY
STATEMENT Elkhorn Police Department
9/2015

The Wisconsin Law Enforcement Standards Board, under LES 2.01(1)(g)1. and 2., requires that a peace officer candidate be examined by a licensed physician or surgeon to ensure that the applicant is free of any physical defect or medical condition which might adversely affect job performance.

The information you provide in this statement is extremely important. The information provided will be used exclusively by a medical health professional to evaluate your qualifications for the position of Patrolman. Please fill out the questionnaire completely and accurately. Please keep in mind that all statements are subject to verification, and, deliberate inaccuracies or omissions may bar or remove you from employment.

This statement was designed to explore those areas which bear directly upon the physical demands of the position for which you have applied. A thorough and accurate evaluation of this information will contribute to sound employment decisions benefiting both you and the City of Elkhorn Police Department.

If hired, the information you provide will be a part of your medical record.

APPLICANT BACKGROUND INFORMATION

Legal Name: Last	First	Middle	Birth Date (m/d/yyyy)	Social Security Number
Resident Street Address AND Mailing Address if Different				
(Area Code) Home Telephone			(Area Code) Work Telephone	

MEDICAL CONSENT

I, the undersigned, consent to undergo a medical examination, including blood specimens, x-rays, skin tests, immunizations, drug screen examinations, and other examinations which the examiners may consider necessary to complete the medical evaluation.

X _____

(Applicant Signature) (Date – m/d/yy)

CERTIFICATION

I certify that all statements made in this Medical History Statement are true and complete, and I understand that any misstatements of material facts may subject me to disqualification or dismissal.

X _____

(Applicant Signature) (Date – m/d/yy)

Instructions: Check the appropriate box. If you are unable to answer a question for any reason, check the "N/A" box.

NO	YES	N/A	
☐	☐	☐	1. Have you been medically examined for employment in this agency before? Your name at that time: _____

2. Please list all medications you regularly use, including vitamins, birth control pills, laxatives, aspirins, antihistamines, tranquilizers, and weight reducing aids.

3. Please list any medicines you have taken in the last 2 months (prescription/non-prescription).

4. Name any drugs to which you may have ever had an allergic reaction.

5. Please list any other substances to which you are allergic, including food, insect stings, etc.

6. Please list your last three hospitalizations, beginning with the most recent (excluding routine childbirth).

Reason	**Hospital/City**	**Date** (m/yyyy)

7. Please list any operations you may have had which are not listed above.

8. If a parent, grandparent, brother or sister has had any of the following diseases, please list in the correct spaces.

Disease	**Mother**	**Father**	**Other**
Diabetes			
Cancer/Tumor			
High Blood Pressure			
Tuberculosis			
Heart Disease			
Hereditary/Family Diseases			

Have you ever been exposed to any of the following, whether at home, work, or in any other setting?

NO	YES	N/A	
☐	☐	☐	9. Prolonged loud noises?
☐	☐	☐	10. Substances which irritated your skin or eyes?
☐	☐	☐	11. Sprays or powders for insects or plants?
☐	☐	☐	12. Prolonged x-rays or other radiation?
☐	☐	☐	13. Dusty conditions such as sandblasting, grinding or drilling of rock, coal, silica, asbestos, or asbestos products?

Have you had a bad reaction to:

NO	YES	N/A	
☐	☐	☐	14. High environmental temperatures?
☐	☐	☐	15. Low environmental temperatures?
☐	☐	☐	16. Have you been rejected by the military for health reasons?
☐	☐	☐	17. Were you ever in the Armed Services? If "Yes", please answer the following:
☐	☐	☐	18. Did you receive a medical discharge?

Have you ever had a claim for the following?

NO	YES	N/A	
☐	☐	☐	19. An occupational disease?
☐	☐	☐	20. An industrial accident?
☐	☐	☐	21. Have you any claim now pending for the above?

If you have ever had or now have any of the following, please check in the appropriate space:

NO	YES	N/A		NO	YES	N/A	
☐	☐	☐	22. Tuberculosis	☐	☐	☐	39. Diabetes (Sugar Disease)
☐	☐	☐	23. Pneumonia	☐	☐	☐	40. Kidney Disease
☐	☐	☐	24. Bronchitis	☐	☐	☐	41. Rheumatism, Arthritis
☐	☐	☐	25. Emphysema	☐	☐	☐	42. Varicose Veins
☐	☐	☐	26. Asthma	☐	☐	☐	43. Phlebitis
☐	☐	☐	27. High Blood Pressure	☐	☐	☐	44. Hay Fever
☐	☐	☐	28. Heart murmur, heart disease	☐	☐	☐	45. Typhoid Fever
☐	☐	☐	29. Rheumatic fever	☐	☐	☐	46. Scarlet Fever
☐	☐	☐	30. Encephalitis, meningitis	☐	☐	☐	47. Valley Fever (Coccidioidomycosis)
☐	☐	☐	31. Epilepsy, convulsions	☐	☐	☐	48. Histoplasmosis
☐	☐	☐	32. Glaucoma	☐	☐	☐	49. Veneral Disease (V.D., Syphilis, Gonorrhea)
☐	☐	☐	33. Duodenal or stomach ulcer	☐	☐	☐	50. Cancer
☐	☐	☐	34. Gall bladder trouble	☐	☐	☐	51. Hyperthyroidism
☐	☐	☐	35. Liver trouble or hepatitis	☐	☐	☐	52. Hypothyroidism
☐	☐	☐	36. Hiatal or diaphragmatic hernia	☐	☐	☐	53. Allergic Rhinitis
☐	☐	☐	37. Sickle cell disease	☐	☐	☐	54. Other:
☐	☐	☐	38. Anemia				

NO	YES	N/A	
☐	☐	☐	55. Have you gained or lost more than 10 lbs. in the past 2 years without trying to do so?
☐	☐	☐	56. Have you had any changes in your appetite in the past 6 months?
☐	☐	☐	57. Have you notices unusual fatigue or weakness recently?
☐	☐	☐	58. Have you been told by a doctor that you had trouble with your thyroid gland?
☐	☐	☐	59. Have you notices changes in your hair or skin color or texture?
☐	☐	☐	60. Have you had a change in size or color of a mole (dark growth) or wart in the past year?
☐	☐	☐	61. Do you have a skin rash, burning, itching or other skin sensitivity?
☐	☐	☐	62. Have you had any skin cancers removed?

NO	YES	N/A	
☐	☐	☐	63. Have you had bleeding gums in the past year?
☐	☐	☐	64. Do you have frequent nosebleeds for no apparent reason?
☐	☐	☐	65. Do you frequently have sinus trouble?
☐	☐	☐	66. Do you have colds more than twice a month?
☐	☐	☐	67. Have you ever coughed up blood?
☐	☐	☐	68. Have you had a chest x-ray in the past 2 years?
☐	☐	☐	69. Do you often cough up a large amount of mucus?
☐	☐	☐	70. Have you ever had a positive TB (tuberculosis) skin test?
☐	☐	☐	71. Do you have unusual shortness of breath?
☐	☐	☐	72. Do your ankles or feet often swell?
☐	☐	☐	73. Have you had a feeling of pressure or tightness in your chest in the past year?
☐	☐	☐	74. Have you had pain in your chest in the past year?
☐	☐	☐	75. Do you sometimes wake up at night short of breath?
☐	☐	☐	76. Do you get pains or cramps in the back of your legs while walking?
☐	☐	☐	77. Do you get pains or cramps in your legs at night?
☐	☐	☐	78. Do you smoke cigarettes? How many per day?
☐	☐	☐	79. Do you use any other forms of tobacco?
☐	☐	☐	80. Do you sometimes have severe soaking sweats at night?
☐	☐	☐	81. Have you had an electrocardiogram (ECG, EKG) in the past 2 years?
☐	☐	☐	82. Do you suffer from indigestion or heartburn?
☐	☐	☐	83. Is swallowing painful or difficult for you?
☐	☐	☐	84. Do you frequently have pain in your stomach or abdomen?
☐	☐	☐	85. Do you frequently take antacid medications, such as Tums or Alka Seltzer?
☐	☐	☐	86. Have you vomited blood or coffee ground-like material?
☐	☐	☐	87. Have you ever had jaundice?
☐	☐	☐	88. Are your bowel movements ever black or bloody?
☐	☐	☐	89. Are your bowel movements ever painful?
☐	☐	☐	90. Have you ever had hemorrhoids?
☐	☐	☐	91. Do you frequently get up at night to urinate (pass water)?
☐	☐	☐	92. Do you ever have difficulty stopping or starting urination?
☐	☐	☐	93. Have you had pain or burning urination?
☐	☐	☐	94. Has your urine ever been red, black, brown, or bloody?
☐	☐	☐	95. Have you ever been told by a doctor that you had sugar or pus in your urine?
☐	☐	☐	96. Have you ever had a bladder or kidney infection?
☐	☐	☐	97. Have you ever passed kidney stones or gravel?
☐	☐	☐	98. Have you ever had a hernia (rupture)? If so, was it surgically repaired?
☐	☐	☐	99. Have you ever had a minor back sprain? If "Yes", please answer the following: a. How many times have you had an attack of this condition? _____ b. How many days were you unable to work because of this condition? _____
☐	☐	☐	100. Have you ever had a severe back injury or an episode of severe back pain? If "Yes", please answer the following: a. How many times have you had an attack of this condition? _____ b. How many days were you unable to work because of this condition? _____
☐	☐	☐	101. Have you had problems with low back pain?
☐	☐	☐	102. Have you ever had a problem with any bones or joints, including fractures, dislocations, limitation of movement, stiffness, or pain? a. If "Yes", please describe the problem(s): _____

NO	YES	N/A	
☐	☐	☐	103. Have you had any fainting spells or seizures?
☐	☐	☐	104. Have you had a skull fracture or a head injury which made you unconscious?
☐	☐	☐	105. Do you suffer from migraine headaches or other bad headaches?
☐	☐	☐	106. When you have a headache, is it relieved by aspirin?
☐	☐	☐	107. Do you have earaches or ear infections often?
☐	☐	☐	108. Do you have ringing or buzzing noises in your ears?
☐	☐	☐	109. Do you sometimes have difficulty hearing what is said to you?
☐	☐	☐	110. Have you had any serious eye infection or injury?
☐	☐	☐	111. Does your eyesight ever blur?
☐	☐	☐	112. Have you had any sudden loss in your vision?

MALE ONLY

☐	☐	☐	113. Have you ever been told by a doctor that you had prostate trouble?
☐	☐	☐	114. Have you ever had an infection in your prostate gland?
☐	☐	☐	115. Have you ever had swelling or pain in your scrotum or testicles?

FEMALE ONLY

☐	☐	☐	116. Do you have monthly menstrual periods?
			117. What was the date of your last period? _____
☐	☐	☐	118. Are your menstrual periods painful?
			119. When was your last pap smear? _____
☐	☐	☐	120. Have you ever notices any unusual lumps in your breasts?
☐	☐	☐	121. Have you ever noticed a discharge from your nipples when you were neither pregnant nor nursing?
			122. How many times have you been pregnant?
			(Check One): ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ More than 5
☐	☐	☐	123. Have you ever had complications during pregnancy or following the delivery of a child?

Describe anything else which you feel may be important in your medical history, including any conditions not specifically referred to in the preceding questions.