MEDICAL HISTORY STATEMENT

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Commission on Peace Officer Standards and Training
1601 Alhambra Boulevard
Sacramento, CA 95816-7083

Pursuant to the Federal Privacy Act (Public Law 93-579 and the Information Practices Act (IPA) of 1977 (Civil Code Sections 1798, *et seq.*), notice is hereby given for the request of personal information. Failure to provide all or any part of the requested information may delay processing of this form, or result in an incomplete record. No disclosure of personal information will be made unless permissible under Article 6, Section 1798.24 of the IPA of 1977. Each individual for whom personal information is collected has the right to inspect that information in any record maintained by POST. Inquiries may be directed to the POST Information Practices Act Coordinator at the address listed above. Contact the POST Information Services Bureau for instructions on requesting records.

INSTRUCTIONS

- POST Regulation 1002(a)(7) requires that peace officer candidates be examined by a licensed physician and surgeon to ensure the absence of any physical defect or medical condition which might adversely affect job performance.
- The information you provide in this statement is extremely important. It will be used by a medical health professional to evaluate your qualifications for the position of entry-level law enforcement officer, which in most agencies consists of the patrol officer function. Therefore, please fill out the questionnaire completely and accurately. Please keep in mind that: (a) all statements are subject to verification; (b) deliberate inaccuracies or incomplete statements may bar or remove you from employment.
- This form must be completed and presented when reporting for your medical examination. This information will assist the examining physician in conducting your medical examination and in making appropriate recommendations.
- When answering questions, place an "X" in the appropriate box. Please explain all "Yes" items in the designated areas. Most individuals will have some "Yes" answers. A "Yes" answer does not necessarily mean that you will be disqualified.
- This statement is confidential. If hired, the information you provide will be part of your medical record, separate from your personnel file.
- Type or legibly print (in ink) required information on printed form. To access this form on the POST website, go to www.post.ca.gov.

SECTION 1: CANDIDATE IDENTIFICATION

CANDIDATE'S NAME (Last, First, Middle)			BIRTHDATE (MM/DD/YYYY)
ADDRESS WHERE YOU CAN BE CONTACTED (Street / P.O. Box)	CITY	STATE	ZIP

PHONE NUMBERS WHERE YOU CAN BE REACHED		E-MAIL
DAY ( ) - EXT	EVENING ( ) - EXT	

SOCIAL SECURITY NUMBER	
- -	(In accordance with the Federal Privacy Act of 1974, disclosure is voluntary. The Social Security Number will be used for identification purposes to ensure that proper records are maintained.)

SECTION 2: CONSENT

I, the undersigned, do hereby consent to undergo a medical examination, including blood and urine testing, x-rays, skin tests, and other examinations which the examiner may consider necessary to complete the medical evaluation. I also authorize the medical examiner to obtain current or past medical records and to discuss my medical status and history with my treating physician or other medical consultants as necessary.

SIGNATURE IN FULL	DATE

SECTION 3: JOB HISTORY

Please list previous jobs that lasted at least six (6) months, including military service.

JOB TITLE	EMPLOYER / LOCATION (CITY, STATE, OR COUNTRY IF OVERSEAS)	EMPLOYMENT DATES (MM/DD/YYYY)
		–
		–
		–
		–
		–
		–

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SECTION 4: MEDICAL HISTORY – Indicate if you have ever had any of the following conditions.

	Y	N	?	EYE, EAR, NOSE, THROAT
1	☐	☐	☐	Eye surgery
2	☐	☐	☐	Need to wear glasses / contact lenses
3	☐	☐	☐	Cataracts
4	☐	☐	☐	Blurred or double vision
5	☐	☐	☐	Color deficiency or blindness to any degree
6	☐	☐	☐	Orthokeratology
7	☐	☐	☐	Radial keratology (refractive surgery) or keratotomy
8	☐	☐	☐	Glaucoma
9	☐	☐	☐	Sinus trouble
10	☐	☐	☐	Hoarseness (frequent or recent)
11	☐	☐	☐	Allergy / hay fever
12	☐	☐	☐	Ruptured ear drum
13	☐	☐	☐	Ringing or buzzing in ears
14	☐	☐	☐	Loss of hearing
15	☐	☐	☐	Ear surgery
16	☐	☐	☐	Earaches

	Y	N	?	RESPIRATORY
17	☐	☐	☐	Asthma (list age of last episode: ______)
18	☐	☐	☐	Shortness of breath
19	☐	☐	☐	Chronic or frequent cough
20	☐	☐	☐	Tuberculosis
21	☐	☐	☐	Emphysema
22	☐	☐	☐	Coughed up blood
23	☐	☐	☐	Pneumothorax (collapsed lung)
24	☐	☐	☐	Pneumonia
25	☐	☐	☐	Sarciodosis
26	☐	☐	☐	Chest tightness
27	☐	☐	☐	Wheezing
28	☐	☐	☐	Blood clot in lungs

	Y	N	?	GASTROINTESTINAL
29	☐	☐	☐	Ulcer / stomach trouble
30	☐	☐	☐	Vomited blood
31	☐	☐	☐	Persistent diarrhea
32	☐	☐	☐	Colitis
33	☐	☐	☐	Recurrent hemorrhoids
34	☐	☐	☐	Gall bladder trouble
35	☐	☐	☐	Hepatitis / jaundice
36	☐	☐	☐	Recurrent stomach pain
37	☐	☐	☐	Mucous in stool
38	☐	☐	☐	Pancreatitis
39	☐	☐	☐	Abnormal liver tests
40	☐	☐	☐	Hernia
41	☐	☐	☐	Ulcerative colitis
42	☐	☐	☐	Irritable Bowel Syndrome
43	☐	☐	☐	Ulcer
44	☐	☐	☐	Chron's disease

	Y	N	?	GENITOURINARY
45	☐	☐	☐	Kidney disease or stone
46	☐	☐	☐	Bladder trouble
47	☐	☐	☐	Difficulty in urinating
48	☐	☐	☐	Blood in urine
49	☐	☐	☐	Prostate trouble
50	☐	☐	☐	Irregular vaginal bleeding
51	☐	☐	☐	Menstrual problem that kept you from work
52	☐	☐	☐	Currently pregnant

	Y	N	?	CARDIOVASCULAR
53	☐	☐	☐	Heart attack or chest pain
54	☐	☐	☐	Heart trouble / murmur
55	☐	☐	☐	Mitral valve prolapse
56	☐	☐	☐	Palpitation (irregular heartbeat)
57	☐	☐	☐	High blood pressure
58	☐	☐	☐	Pain or discomfort in chest
59	☐	☐	☐	Rheumatic fever
60	☐	☐	☐	Swelling of feet
61	☐	☐	☐	Leg pain on walking
62	☐	☐	☐	Painful varicose veins

	Y	N	?	MUSCULO SKELETAL
63	☐	☐	☐	Fractures / broken bones
64	☐	☐	☐	Back trouble / pain or sciatica
65	☐	☐	☐	Neck trouble / pain
66	☐	☐	☐	Numbness of extremities
67	☐	☐	☐	Shin pains
68	☐	☐	☐	Arthroscopy
69	☐	☐	☐	Arthritis / rheumatism

	Y	N	?	JOINT INJURY / SURGERY / DISLOCATION / PAIN / SWELLING
70	☐	☐	☐	Shoulder
71	☐	☐	☐	Elbow
72	☐	☐	☐	Wrist
73	☐	☐	☐	Finters / toes
74	☐	☐	☐	Hip
75	☐	☐	☐	Knee
76	☐	☐	☐	Ankle/ foot

	Y	N	?	NEURO-PSYCHIATRIC
77	☐	☐	☐	Epilepsy
78	☐	☐	☐	Convulsions / seizures
79	☐	☐	☐	Fainting spells / blackouts
80	☐	☐	☐	Recurrent dizziness
81	☐	☐	☐	Head injury
82	☐	☐	☐	Frequent / recurrent headaches
83	☐	☐	☐	Stroke
84	☐	☐	☐	Skull defect
85	☐	☐	☐	Meningitis / encephalitis
86	☐	☐	☐	Need psychological care
87	☐	☐	☐	Mental hospitalization
88	☐	☐	☐	Attention deficit disorder
89	☐	☐	☐	Dyslexia

	Y	N	?	MISCELLANEOUS
90	☐	☐	☐	Diabetes (glucose in urine)
91	☐	☐	☐	Low blood sugar
92	☐	☐	☐	Thyroid trouble
93	☐	☐	☐	Bleeding tendencies
94	☐	☐	☐	Anemia
95	☐	☐	☐	Enlarged glands
96	☐	☐	☐	Cyst / tumor
97	☐	☐	☐	Skin problems / rashes
98	☐	☐	☐	Wool allergy
99	☐	☐	☐	Non-healing sores
100	☐	☐	☐	Recent change in a wart or mole
101	☐	☐	☐	Cancer / leukemia
102	☐	☐	☐	Chronic fatigue
103	☐	☐	☐	Night sweats
104	☐	☐	☐	Undesired weight loss or gain
105	☐	☐	☐	Heat stress
106	☐	☐	☐	Environment illness
107	☐	☐	☐	Multiple chemical sensitivity
108	☐	☐	☐	Fever lasting 1 month or more
109	☐	☐	☐	Eczema
110	☐	☐	☐	Gulf War Syndrome
111	☐	☐	☐	Any other problem or illness not listed that may affect job performance

SECTION 5: MEDICAL CONDITION EXPLANATION(S)

Provide explanations for any medical condition(s) marked "yes" in Section 4. Reference the corresponding item number in your response.

ITEM #	EXPLANATION	ITEM #	EXPLANATION

SECTION 6: OTHER MEDICAL

Please answer each of the following questions:

Y N ?

☐ ☐ ☐ 112. Have you ever had a medical exam for employment as a peace officer?
If yes, a) What year? b) For what agency / municipality:

☐ ☐ ☐ 113. Have you worked as a peace officer before? If yes, where:

☐ ☐ ☐ 114. Describe your typical exercise or physical activity including that at work; indicate how often and how long you've been doing it.

	EXERCISE / ACTIVITY	HRS/WEEK	HOW LONG?
a)			yrs mos
b)			yrs mos
c)			yrs mos

☐ ☐ ☐ 115. Have you ever coughed, wheezed, or had chest discomfort after exercise?

☐ ☐ ☐ 116. Do you ever become short of breath when walking with other people of your own age at level ground?

☐ ☐ ☐ 117. Do you currently smoke cigarettes? If yes, a) How many packs per day? b) For how long (in years)?

☐ ☐ ☐ 118. Are you an ex-smoker? If yes, a) How many years did you smoke? b) How many packs per day? c) What year did you quit?

☐ ☐ ☐ 119. Are you now or have you ever been enrolled in a drug or alcohol rehabilitation program? If yes, please give description and dates.

	PROGRAM	FROM – TO (MM/DD/YYYY)
a)		–
b)		–

120. When was your last alcoholic drink? __________ a) ☐ I do not drink alcohol. b) ☐ I am a light drinker (two or less drinks per week).
c) I drink (per week): bottles/cans of beer glasses of wine bottles of wine shots of hard liquor

☐ ☐ ☐ 121. Have you ever been medically disqualified or terminated from employment due to a positive drug or alcohol test?

☐ ☐ ☐ 122. Have you recently been exposed to smoke or any noxious or chemical fumes?

123. Describe any hobbies or recreational activities that expose you to noise or chemicals.

	HOBBY / ACTIVITY	TYPE OF NOISE / CHEMICAL
a)		
b)		

☐ ☐ ☐ 124. Have you been exposed to loud noise today? If yes, were you wearing ear protection? ☐ Yes ☐ No

☐ ☐ ☐ 125. Have you ever been unable to hold a job or been refused employment because of any physical, mental, or other medically related reason?

☐ ☐ ☐ 126. Have you ever been rejected for or discharged from a military position because of any physical, mental, or other medically related reason?

127. I am: ☐ right-handed ☐ left-handed

SECTION 6: OTHER MEDICAL *continued*

Y N ?

☐ ☐ ☐ 128. Have you ever taken any illegal drugs? If yes, list type, frequency and date last used.

	TYPE OF ILLEGAL DRUG	FREQUENCY	DATE LAST USED
a)			
b)			

☐ ☐ ☐ 129. Have you taken any prescription or over-the-counter medications in the last 12 months? This would include vitamins, birth control pills, antacids, laxatives, aspirins, antihistamines, and weight reducing aids. If yes, list name and dosage.

	PRESCRIPTION / MEDICATION	DOSAGE		PRESCRIPTION / MEDICATION	DOSAGE
a)			c)		
b)			d)		

☐ ☐ ☐ 130. Have you ever been absent from work due to stress?

☐ ☐ ☐ 131. Have you ever had any surgical operations? If yes, list the type of surgery and when it was performed.

	TYPE OF SURGERY	DATE OF SURGERY
a)		
b)		

☐ ☐ ☐ 132. Have you been hospitalized (at least overnight)? If yes, list the year, your age, reason and length of stay.

	YEAR HOSPITALIZED	AGE	REASON	LENGTH OF STAY
a)				
b)				

☐ ☐ ☐ 133. Are you currently under a doctor's care?

☐ ☐ ☐ 134. Are you currently limited by any temporary condition (e.g., broken bone, pregnancy, recovery from surgery)? Please describe in Section 7.

☐ ☐ ☐ 135. Have you ever had any doctor-imposed activity restrictions? Please describe in Section 7.

☐ ☐ ☐ 136. Have you ever been to a doctor for back/neck pain or problems?

☐ ☐ ☐ 137. Have you ever been off work because of back/neck pain or problems?

☐ ☐ ☐ 138. Is there any history of heart disease in your immediate family?

☐ ☐ ☐ 139. Do any diseases run in your family? Please list:

☐ ☐ ☐ 140. Do you or anyone in your family have high cholesterol?

☐ ☐ ☐ 141. Do you currently have a cold/cough, or have you had either in the last two weeks?

☐ ☐ ☐ 142. Have you missed more than five (5) days from work due to medical reasons in the past 12 months?

SECTION 7: ADDITIONAL EXPLANATIONS AND SIGNATURE

Briefly explain any items marked "Yes" in Section 6. In addition, describe anything else which you feel may be important in your medical history, including any condition(s) not specifically referred to in the preceding questions.

ITEM #	EXPLANATION	ITEM #	EXPLANATION

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

SIGNATURE IN FULL	DATE