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| The purpose of the questions in this form is to gather information concerning your health and physical condition, both now and in the past. (POST Rule 464-3-.02 requires that officers be found, after examination by a licensed physician or surgeon, to be free from any physical, emotional, or mental conditions which might adversely affect his/her exercising the powers or duties of a peace officer. ) This information will be used only to determine whether you can safely complete the required training and safely perform such duties. Please answer all of the following questions as fully and completely as you can. If you don’t understand a question, or are unsure of how to answer it, leave it blank and request assistance from your hiring agency or your physician. Most individuals will have some “yes” answers, and it is not necessarily a disqualification. THIS FORM IS FOR THE PHYSICIAN ONLY AND IS TO BE GIVEN BY THE CANDIDATE TO THE PHYSICIAN AT THE EXAM.  |
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| Last Name | First Name | Middle Name |
| DATE OF BIRTH (mmddyyyy)  | Check if applies:[ ] Jr. [ ]  Sr.[ ] III [ ]  IVOther:\_\_\_\_\_ | MAIDEN NAME | SEX: [ ]  Male [ ]  FemaleSocial Security Number: |
| The job/position that candidate is applying for is: |
| AGENCY APPLYING WITH | AGENCY PHONE# (AREA CODE) - NUMBER*( )-* ***-*** |
| NAME OF AGENCY CONTACT(Person Processing Application w/in Agency) | CONTACT PHONE#(AREA CODE) - NUMBER*( )-* ***-*** |
| ATTESTATION: I certify under penalty of perjury, that the information given by me is true to the best of my knowledge and belief. I agree and understand that any misstatements of material facts may cause forfeiture on my part of all right to employment as a peace officer in the State of Georgia, may result in dismissal after appointment; or may result in loss of entitlement to disability retirement benefits. My signature also indicates that I understand all of the questions on this medical history form.CANDIDATE’S SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ***INDIVIDUAL HISTORY - TO BE COMPLETED BY THE CANDIDATE (Use Ink Only)*** |
| MEDICAL CONDITIONS INSTRUCTIONS: Do you have or have you ever had any of the following:(Check every item.If “YES”, give year of most recent medical occurrence & explain on page 3.) |
| ***Health Condition*** | Yes  | Year | No | ***Health Condition*** | Yes  | Year | No |
| **CARDIOVASCULAR SYSTEM (HEART & BLOOD VESSELS)** |   |   |   | **SKIN** |   |   |   |
| 1. Heart Attack |   |   |   | 12. Rash |   |   |   |
| 2. Hardening of the arteries (Arteriosclerosis) |   |   |   | 13. Hives |   |   |   |
| 3. High or low blood pressure |   |   |   | 14. Moles that bleed/get larger |   |   |   |
| 4. Heart Murmur |   |   |   | 15. Change in color of skin (other than suntan) |   |   |   |
| 5. Palpitations or irregular heart beat |   |   |   | 16. Frequent boils/abscesses |   |   |   |
| 6. Episodes of chest pains, tightness, discomfort |   |   |   | 17. Trouble with fingernails |   |   |   |
| 7. Shortness of breath |   |   |   | 18. Small itching blisters on the side of fingers or palms |   |   |   |
| 8. Varicose veins |   |   |   | 19. Sores that do not heal |   |   |   |
| 9. Swelling of ankles, feet or legs (edema) |   |   |   | 20. Other skin conditions |   |   |   |
| 10. Leg pains, cramps |   |   |   |   |   |   |   |
| 11. Other cardiac conditions |   |   |   |   |   |   |   |
| ***Health Condition*** | Yes  | Year | No | ***Health Condition*** | Yes  | Year | No |
| **EYES & VISION** |   |   |   | **HEAD, NOSE, MOUTH & THROAT** |   |   |   |
| 21. Glaucoma |   |   |   | 51.Persistent severe headaches |   |   |   |
| 22. Cataract |   |   |   | 52. Frequent nose bleeds |   |   |   |
| 23. Eye irritations (itching or burning) |   |   |   | 53. Frequent nasal congestion |   |   |   |
| 24. Eye infection |   |   |   | 54. Persistent or severe sinus condition |   |   |   |
| 25. Defective vision |   |   |   | 55. Bleeding gums |   |   |   |
| 26. Color blindness |   |   |   | 56. Persistent or severe dental condition |   |   |   |
| 27. Injury to eye |   |   |   | 57. Hoarse when don't have cold |   |   |   |
| 28. Eye surgery |   |   |   | 58. Difficulty swallowing |   |   |   |
| 29. Double vision |   |   |   | 59. Persistent sore throat |   |   |   |
| 30. Glasses |   |   |   | 60. Loss of taste or smell |   |   |   |
| 31. Contact lenses |   |   |   | 61. Head injury |   |   |   |
| **EARS & HEARING** |   |   |   | 62. Other head, nose, mouth, or throat conditions |   |   |   |
| 32. Hearing difficulties |   |   |   | **BLOOD/LYMPH (HEMATOLOGIC) SYSTEMS** |   |   |   |
| 33. Use hearing aid |   |   |   | 63. Anemia |   |   |   |
| 34. Ringing in the ears (tinnitus) |   |   |   | 64. Bleeding disorder |   |   |   |
| 35. Perforated ear drum |   |   |   | 65. Sickle cell disease or trait |   |   |   |
| 36. Persistent or severe ear infection |   |   |   | 66. Phlebitis/blood clot |   |   |   |
| 37. Other ear or hearing conditions |   |   |   | 67. Blood transfusion |   |   |   |
| **RESPIRATORY SYSTEM (LUNGS & BREATHING)** |   |   |   | 68. Chills, fever, night sweats |   |   |   |
| 38. Persistent or severe colds |   |   |   | 69. Lymph node or persistent glandular swelling |   |   |   |
| 39. Persistent or severe cough |   |   |   | 70. Other conditions of blood or lymph |   |   |   |
| 40. Coughing blood |   |   |   | **GASTROINTESTINAL SYSTEM (STOMACH & INTESTINES)** |   |   |   |
| 41. Asthma or breathing difficulty |   |   |   | 71. Persistent or severe nausea or indigestion |   |   |   |
| 42. Emphysema |   |   |   | 72. Persistent or severe stomach pain |   |   |   |
| 43. Pneumonia |   |   |   | 73. Vomiting blood |   |   |   |
| 44. Tuberculosis |   |   |   | 74. Persistent or severe vomiting |   |   |   |
| 45. Other lung or breathing condition |   |   |   | 75. Hernia (rupture) |   |   |   |
| **LIVER, SPLEEN, & GALLBLADDER** |   |   |   | 76. Stomach or duodenal ulcer |   |   |   |
| 46. Cirrhosis |   |   |   | 77. Colitis |   |   |   |
| 47. Hepatitis |   |   |   | 78. Hemorrhoids or piles |   |   |   |
| 48. Yellow jaundice |   |   |   | 79. Change in bowel habits |   |   |   |
| 49. Gallstones |   |   |   | 80. Block stool or blood in stool |   |   |   |
| 50. Other conditions of liver, spleen, or gallbladder |   |   |   | 81. Persistent or severe constipation |   |   |   |

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| ***Health Condition*** | Yes  | Year | No | ***Health Condition*** | Yes  | Year | No |
| **KIDNEYS & URINARY TRACT** |   |   |   | **GASTROINTESTINAL SYSTEM (STOMACH & INTESTINES) cont.** |   |   |   |
| 82. Kidney stones |   |   |   | 111. Persistent or severe diarrhea |   |   |   |
| 83. Kidney infection |   |   |   | 112. Pancreatitis |   |   |   |
| 84. Blood or pus in urine |   |   |   | 113. Appendicitis |   |   |   |
| 85. Pain or burning when urinating |   |   |   | 114. Other conditions of stomach or intestines |   |   |   |
| 86. Frequent urination |   |   |   | **MUSCULOSKELETAL SYSTEM** |   |   |   |
| 87. Albumen or protein in urine |   |   |   | 115. Arthritis |   |   |   |
| 88. Prostate condition |   |   |   | 116. Bursitis/tendonitis |   |   |   |
| 89. Burning discharge from penis |   |   |   | 117. Swollen or painful joints |   |   |   |
| 90. Other conditions of kidneys or urinary tract |   |   |   | 118. Dislocations |   |   |   |
| **REPRODUCTIVE SYSTEM (FEMALES ONLY)** |   |   |   | 119. Painful or trick shoulder |   |   |   |
| 91. Pregnant at present |   |   |   | 120. Elbow problems |   |   |   |
| **NEUROLOGICAL (NERVOUS) SYSTEM** |   |   |   | 121. Wrist or hand problems |   |   |   |
| 92. Epilepsy, convulsions, seizures |   |   |   | 122. Back pain |   |   |   |
| 93. Periods of blackouts/loss of consciousness |   |   |   | 123. Back surgery |   |   |   |
| 94. Fainting spells |   |   |   | 124. Trick or locked knee |   |   |   |
| 95. Dizzy Spells (vertigo) |   |   |   | 125. Knee surgery |   |   |   |
| 96. Memory difficulty |   |   |   | 126. Foot problems |   |   |   |
| 97. Tremor of the hands or head |   |   |   | 127. Bone infection |   |   |   |
| 98. Paralysis of any type |   |   |   | 128. Broken or fractured bone |   |   |   |
| 99. Stroke |   |   |   | 129. Persistent or severe muscle aches or pains |   |   |   |
| 100. Severe numbness, tingling or weakness |   |   |   | 130. Other Musculoskeletal conditions |   |   |   |
| 101. Dyslexia/learning difficulty |   |   |   | **ENDOCRINE/METABOLIC SYSTEM** |   |   |   |
| 102.Other conditions of neurological (nervous) system |   |   |   | 131. Diabetes |   |   |   |
| **CANCER** |   |   |   | 132. Thyroid condition or disease |   |   |   |
| 103. Surgery |   |   |   | 133. Hypoglycemia |   |   |   |
| 104. Radiation Therapy |   |   |   | 134. Unexplained weight gain or loss |   |   |   |
| 105. Chemotherapy |   |   |   | 135. Unusual loss or growth of body hair |   |   |   |
| 106. Immunotherapy |   |   |   | 136. Gout |   |   |   |
| 107. Hormone Therapy |   |   |   | 137. Osteoporosis or other bone disease |   |   |   |
| 108. Breast |   |   |   |  |   |   |   |
| ***Health Condition*** | Yes  | Year | No | ***Health Condition*** | Yes  | Year | No |
| **CANCER cont** |   |   |   | **ENDOCRINE/METABOLIC SYSTEM cont** |   |   |   |
| 138. Bone |   |   |   | 153.Osteoporosis or other bone disease |   |   |   |
| 139. Skin |   |   |   | **ALLERGIES (CAUSED BY:)** |   |   |   |
| 140. Other |   |   |   | 154.Medication |   |   |   |
| **PSYCHOLOGICAL/MOOD** |   |   |   | 155. Rheumatic fever |   |   |   |
| 141. Mental problem requiring hospitalization |   |   |   | 156. Food |   |   |   |
| 142. Suicide/attempted suicide |   |   |   | 157. Soaps or detergents |   |   |   |
| 143. Active psychosis |   |   |   | 158. Pollen |   |   |   |
| 144. Drug,narcotic or alcohol |   |   |   | 159. Insect bites/scales |   |   |   |
| 145. Persistent or severe depression/worry |   |   |   | 160. Other:  |   |   |   |
| 146. Other psychological conditions |   |   |   |  |   |   |   |
| **INFECTIOUS CHILDHOOD DISEASES** |   |   |   |  |   |   |   |
| 147. Meningitis/encephalitis |   |   |   |  |   |   |   |
| 148. Polio |   |   |   |  |   |   |   |
| 149. Mumps |   |   |   |  |   |   |   |
| 150. Measels |   |   |   |  |   |   |   |
| 151. Venereal Disease |   |   |   |  |   |   |   |
| 152. Other: |   |   |   |  |   |   |   |
|  |   |   |   |  |   |   |   |
|   |   |   |   |  |   |   |   |
| EXPLANATION OF ANY ITEMS CHECKED “YES”.  |
| CURRENT MEDICATIONS: (Please list.) |
| SURGICAL HISTORY: Have you ever had surgery? [ ]  Yes [ ]  No1. Type of Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date (Mo/Yr): \_\_\_\_\_\_\_\_\_\_\_\_\_\_2. Type of Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date (Mo/Yr): \_\_\_\_\_\_\_\_\_\_\_\_\_\_3. Type of Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date (Mo/Yr): \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| HOSPITALIZATION HISTORY: Have you ever had been hospitalized? [ ]  Yes [ ]  No1. Reason:Date (Mo/Yr): 2. Reason:Date (Mo/Yr):3. Reason:Date (Mo/Yr): |